A prison called me : a clients perspective of some of the emotional effects of living with dissociative identity disorder and how they can affect behaviour

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ABSTRACT.

"A man has as many social selves as there are individuals who recognise him and carry an image of him in their minds"
(William James 'Principles of Psychology 1890)

When faced with overwhelming trauma the human psyche finds ingenious ways to protect itself. Dissociation is the ability to take a part of the mind away from one's own immediate situation or surroundings. It is a natural ability that we all have and we all dissociate several times every day. There are varying degrees of dissociation, or varying depths. At one end of the dissociative scale is the ability to day dream, go into highway hypnosis, or become deeply involved in a book or film. On the mid range of the scale are altered states of consciousness that could be described as a trance, prayer or meditation. Yoga teaches dissociation. On the far end of the scale is the ability to split the mind completely into different personalities or parts and to have out of body experiences where the dissociated part of the mind actually witnesses the actions of the body. This thesis looks at the far end of the scale at Dissociative Identity Disorder which is an attempt by the human mind to deny an unbearable situation or anticipation of it and to protect itself from annihilation. Inevitably there are lasting consequences to such an extreme coping mechanism.

In looking at this phenomenon I have attempted to discover some of the feelings that are connected with dissociation and how they can affect behaviour in someone with Dissociative Identity Disorder. In order to achieve this I have engaged in qualitative research using a single case study. It is a very personal research project as the researcher is also the researchee. Data has been gathered from on going counselling sessions for a period of two-and-a-half years using audio taped sessions. Analysis of the data has been done using a heuristic approach with one tape being analysed using a grounded theory approach. Because of the vast amount of data collected tapes for analysis have been randomly selected.

We all see what we want to see according to our needs at the time. Beneath the complex layers of our own individual mask of self-created illusion which we call 'our truth' are other complex layers of our reality. The process of dipping into these hidden truths takes us from the peak of the iceberg, which is the conscious mind, into the realms of the unconscious mind below the surface. When we have dipped into this realm of the unconscious we begin to discover the true self and the deeper we go the more we come to realise that the difference between us as individuals begins to disintegrate. Eventually we learn that we are all very much the same beneath the surface.

I hope the reader is able to gain some insight into and perhaps a greater awareness of human reaction to trauma.

Anne Burdess

Copyright Declaration

Degree Declaration

The work contained in this dissertation is submitted in fulfilment of the requirement for the degree in PhD in Counselling and represents an independent contribution by the author.

This work has not been previously submitted by the author for a degree at this or any other university.

ACKNOWLEDGEMENTS.

No matter what accomplishments we make somebody has helped us. There are several people whom I wish to thank.

My family, particularly my three daughters, and my friends have endured the brunt of my descent into the world of research. They have been both supportive and encouraging and even pushy during the times of despair when I wanted to give up. I love them dearly for their patience and tolerance.

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Without the technical help and patience of Neil Holmes I doubt I would have mastered the complexities of the computer.

I owe a debt of gratitude to a lady I have never met, Patricia Karg whose artistic work struck a chord. She has kindly given me permission to use some of her illustrations which I first saw in the book *'Job and the Mystery of Suffering: Spiritual Reflections'* by Richard Rohr. Her work can be seen on the website www.karg-patricia.com .Thank you. (Appendix E)

I would like also to acknowledge and thank members of the United Kingdom Society for the Study of Dissociation (UKSSD) who always responded to requests for help when looking for references and for their continued work with dissociation and research.

Finally, I still cannot find language that can adequately express my thanks to **K** my counsellor and research participant. His continued support, acceptance and unswerving belief in me have never wavered. From him I have experienced a Christian love I would never have thought possible. Without him, not only is it true to say that this project would not have been considered let alone reach fruition but 'I' would not be here. I have been truly blessed in the love and friendship I have received from him. We continue to walk through the darkest of forests and he is the torch that lights the way. One day we *will* come through. Thank you still seems so wanting but 'thank you' anyway.

'The task ahead of us is never as great as the power behind us.'
(Alcoholics Aonymous)

This thesis is dedicated to

Kevin

The power behind me, and my friend.

'Do not go where the path may lead, go instead where there is no path and leave a trail'
(Ralph Waldo Emerson)

Illustrations and Tables

'The journey of a thousand miles begins with a single step'
(Chinese Proverb)

CHAPTER 1.

INTRODUCTION.

"We shall not cease from exploration and the end of all our exploring will be to arrive where we started and know the place for the first time."
T.S.Eliot.

When faced with overwhelming trauma the human psyche finds ingenious ways to protect itself. This dissertation looks at one of these ways. Dissociative Identity Disorder is an attempt by the human mind to deny an unbearable situation and to protect itself from annihilation. Whilst it holds a place in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as an Axis 1 disorder and described as a "hysterical" response to a situation, I believe from my own experiences that it is a normal adaptive response to severe trauma and not a psychotic response. I hope this thesis will convince its readers that this is the case. Inevitably there are lasting consequences to such an extreme coping strategy and again I hope this study aims to enlighten its readers to some of the emotional effects of Dissociative Identity Disorder.

Dissociative Identity Disorder (DID) is a contentious subject. There are those who would argue for its existence (Bliss 1986: Kluft 1985, 1992: Ross 1997: Putnam 1986: Mollon 1998, 2002) and there are those who are sceptical (Allison 1980: Aldridge-Morris 1989). Whatever views we hold the continued research that is being conducted in psychobiological fields (Nijenhuis 2002, 2003: Vedat Sar 2002) is exciting and suggests that there is now more reliable evidence than the words and presenting symptoms of those who are purported to live with the experience of Dissociative Identity Disorder. This will be explored in more detail in Chapter 2.

DID is a valid phenomenon often misdiagnosed (Ross1997: Bliss 1986). It has been the subject of much valuable research. When looking into the phenomenon for my own interest I was struck by the lack of research into the emotional side of DID and the absence of any research undertaken from the perspective of the client. This is one of the reasons that led me to embarking on this study.

Theory produces guidelines and, like anything else, guidelines are a developing process of understanding. Theories are important; they offer contrasting explanations for phenomena and tell us what we may expect in a given situation. However theories are inevitably a distortion of what they try to represent; part of their value is that they simplify. I see the need to replace the approach of selecting the 'correct' theoretical explanation from a series of choices and instead look for 'organic' complexity. The need therefore is to relate theories to personal experience which has not always been the case with Dissociative Identity Disorder. As far as I have been able to find there has been no research conducted by someone who dissociates and who is currently in therapy so hence there is nothing to actively compare to the little theory there is on emotions equated with Dissociative Identity Disorder.

Much of the valuable research into Dissociative Identity Disorder and its subsequent theory is in the area of aetiology, gender relation, psycho-biology, treatment and outcomes and other related areas which I will allude to later in this study in Chapter 2. There is also the ever ongoing debate as to its authenticity between the well known proponents, such as Bliss, 1986; Ross, 1989, 1997; Kluft, 1985; Mollon, 1996; Nijenhuis, 2002 and the sceptics such as Loftus, 1995: Aldridge-Morris, 1989: Spanos, 1985, 1997; Pendergrast, 1998.

We are all individuals and our response to given situations is unique. I have not set out to produce dry theories or hypotheses but to offer further and perhaps some deeper insights into emotions that can be around for someone who dissociates in the hope that it will contribute to the developing understanding of Dissociative Identity Disorder. It can be very painful to discover that we do not fit guidelines laid down. Being placed outside the 'mainstream' theories can be a lonely place indeed. I hope this study will in some way broaden the constraints of current guidelines and theories.

1. REASON FOR SUBJECT CHOICE AND CONTINUED DEVELOPMENT OF INTEREST.

"Clinicians would say that I 'suffer' from Dissociative Identity Disorder (DID). For as long as I can remember I have been 'different' from other people. At first I thought that the way I behaved was exactly the way that everyone else did and it never crossed my mind to question it or discuss it with anyone else. What I did was my way of coping with the realities of my life and I thought it was the accepted thing to do. It wasn't until I realised that what was happening to me as a child on a daily basis was not happening to other children that it became apparent that my method of coping with the horrors of every day life was not the way my friends or others were behaving. This realisation only served to further isolate an already lonely child and I did my utmost then to hide it from all those around me. Although it was a normal existence for me I had some innate sense now that it would not be accepted, that I would be considered some sort of freak, if not mad. I was afraid of the consequences of people finding out. I had no idea that the medical/psychiatric Fraternity had given it a name!" (Burdess 2000. p.2)

Eight years ago I entered into counselling. I was in my early forties. Because of my previous experiences, it took a long time for any sense of autonomy to occur and to do this I had to internalise the safety of the counselling relationship. Before entering into counselling I had no prior idealised person so found it almost impossible to mobilise the trust that is necessary for internalisation and growth. It was (and is) with patience,

a genuine desire to understand, acceptance and a willingness to voyage into uncharted territory and unfailing belief in 'me' that this counsellor has given me the strength to look not only at my experiences, reactions to them and my consequent coping strategies, but also at what constitutes 'me'. He has taught me that not only do I have the right to emotions and feelings but that it is both normal and healthy to have them – and to have them in 'my' own right. This counsellor was not trained in or experienced in dealing with DID and once described the process as "flying by the seat of my pants". We have come a long way over the years. It has been a difficult and often almost impossible journey but I have grown to trust him over those years and am willing to continue 'flying by the seat of our pants' rather than trade him in for an 'expert' in the field. He has an integrity that is second to none and although we have made mistakes in our process on the way, we continue to have a mutual respect and trust in each other. His willingness to accept and work with the dissociative parts of 'me' has been the backbone of 'my' growth and of 'my' learning and understanding of self, slow though that progress often is.

This research is built on the back of a study I completed in 2000 for a Masters degree, looking at what some of the overriding feelings are for someone living with DID and their effects. Doing the MA research made me very aware of an area that has been vastly neglected in terms of research and therefore understanding. The MA was a minor study which highlighted the expanse of the subject and a need for an in depth pursuit. I was uncovering an enormous potential for discovery in how those who live with Dissociative Identity Disorder feel and how they can respond to those feelings. It felt imperative that I continued looking at this field as the constraints of a Masters' research meant that much of what needed to be said had to be omitted as what was

explored came during a relatively short period of therapy and I was tied by the number of words I could use. This research allows me to explore a far longer period of therapy, in effect two-and-a-half years (June 2000 – December 2002) The data for this research began six months after the data was collected for the MA. This in itself brought greater insights in that feelings are not static. They are fluid and change with newer or better understanding of experiences and information, and when we are able to put experiences into perspective. So, as therapy continues and things become clearer, some emotions dissipate and others surface. It is therefore important to recognise that what is discovered is relevant to that time in the therapeutic process.

In looking at the literature and research around the subject, I found a wealth of material with regard to such things as aetiology, prevalence, ways to treat, expected outcomes, all very clinical and written mostly by therapists, clinicians and psychologists – the experts. It gave me a knowledge base and a medical understanding of my 'condition'. It gave what was happening to me a name. It gave me statistics, models, hypotheses and findings. It gave me insights into the turbulent world of the seemingly endless debate on the validity of the 'condition'. What it did not do was give me reassurance: reassurance that I was real, a valuable and valid member of society who has every right to her feelings and opinions. It gave me no insights into how I could expect to feel. It had the effect of isolating me even further from the society I was struggling to be a part of. It made me a statistic.

As I have said, looking at the literature around the subject of DID. I was aware that there is a wealth of material from the clinician/therapist's perspective but a great dearth of material from the eye of the client especially in the area of how it feels to

live with the ability to dissociate and be labelled dissociative and the subsequent emotions that this brings. I found very little literature written by multiples specific to their feelings around dissociation. What was available tended either to be second hand, reported through the therapist or clinician treating the DID client, cameos in text books or through accounts describing the practicalities of being dissociative and life stories. This was encouraging in the sense that I could see similarities to my own existence but I wanted to know what feelings (if any) were around for them in connection with their dissociation and how they affected their lives. I could find no evidence of research done by a client in therapy into their emotions felt as a result of their life's experiences and subsequent dissociation. I began questioning and challenging what was written and making comparisons with my own experience. The findings for me were significant – enough to encourage me to look deeper into this area. I found that it furthered my awareness of human reaction to trauma and has given me a greater insight into the world that I inhabit. The experience has, I think, enabled me to carry the knowledge gained from it into my own counselling practice to help in the recovery process of my clients.

> "It's in vain, Trot, to recall the past, unless it works some influence on the present."
> (Charles Dickens. 'David Copperfield')

My fear lies in how it will be received. How do I challenge those research methodologists who would have me measure my experiences and findings? As John McGuiness (2001) asks, "How do you measure pain?" I ask, "How do you measure anger, shame or fear?" More to the point though, perhaps we should ask who. Who should measure pain? Who should research and analyse these emotions: should it be a bystander or the therapist or should it be the person(s) experiencing the feeling? We

could argue that it depends on the information we want to know. If we need to know general information about numbers, prevalence, gender or origins then a bystander would suffice and a quantitative research would produce answers. If we want to understand the complexity then it is first hand experience we need and an in depth qualitative study.

I was heartened at a recent lecture given by John McLeod (2003) 'Counselling and Research' when he advocated that more research should be undertaken by clients. He talked of the role of counselling research in relation to the reconstruction of practice and how it contributes to the creation of communities of practice. He continued to explain how research can enhance public understanding and how it can impact on clients. This was my very reason for doing this research. It feels that there is a deficit in research and knowledge in the understanding of how DID clients could feel and what emotions they may expect to experience. Who better to do this research than a client? McLeod (2003) was encouraging systematic case studies and research done by clients as well as sociologists, anthropologists, economists and clinicians. As a therapist myself I agree with his thinking that case studies are often more meaningful to the practitioner than statistical analysis and that we need more research done by the clients. As therapists we work with clients. Who better to inform us of their complexities which we work with together than them?

In an interview in the Guardian newspaper (2005) Peter Beresford, a professor at Brunel University, talked of his experiences as a long term user of the mental health system and believes he is the first "out" mental health service user to become a professor and has written a paper '*The Changing Role of Professor: Including*

everyone's knowledge and experience" (2004) in which he advocates the importance of research into personal experience.

> "As we have all become more conscious of who we are, our place in society and why we do what we do, as women and men, black and white, enlightenment based assumptions of objectivity and traditional positivist approaches to learning and knowledge have been challenged – in science as in art – and new debates developed about the relation of subjectivity to academic study." (p1)

Beresford's experience of the mental health system from in-patient to group therapy, from psychiatrist to psychologist over many years has equipped him to "develop a new type of 'user controlled' research where disabled people and other service users initiate their own research topics" (Guardian 2005). In doing so they are able to raise questions and challenge knowledge based on the traditional assumptions of validity. I found this encouraging and it reinforced my own beliefs that individual experiences have a valid place in expanding knowledge and understanding. Beresford (2004) says

> "Furthermore, because interest in an academic career has often grown out of people's personal experience, its relation with the world that they live in and the desire to address issues which have confronted them, academic curiosity has increasingly been coupled with a commitment to change. This encourages a natural and ready relationship with the world outside and a belief that academe should be part of its community, challenging, not perpetuating, traditional preconceptions about 'ivory towers'." (p2)

I was aware of the limitations of a Masters work and at the time felt fettered by them. Time and word limits restricted the study. This study gives me a greater scope although I have to admit there were times when the very size of it became overwhelming in itself. I was faced with data spanning two-and-a-half years of therapy. It is a continuation of the Masters in as much that it is looking at what feelings are around for someone with DID and their likely effects. The big difference

in this study compared to the MA, besides an increased length of time for collection of data, is a more in depth introduction of the alter personalities and their greater involvement. The wealth of material obtained has also allowed for a broader and more in depth exploration of traditional thinking and theory.

I am also aware of the shortcomings of this research and possible perceptions of its shortcomings, the fact that it is conducted with only one subject writing about subjective experience inevitably raises questions about whether it accounts as research; possible criticisms of this kind will be considered in the methodology chapter. Also it is again time limited (partly because the therapy is ongoing and will continue to be so until 'I' feel that I have resolved as much as I can) and therefore restricted to where the counselling process is at the time of the study. In not being able to find any similar research I have nothing to which this can be compared or contrasted. But once again I feel the findings are worth consideration by both sufferers and those who treat and help them. Research in any field has to start somewhere. Research, too, needs to be fed back to individual practitioners and offered to clients as well.

1.2. STRUCTURE OF THESIS.

In 2000 I completed some research for a Masters, the title of which was "What are some of the overriding feelings experienced by a client with Dissociative Identity Disorder and their effects?" In that study the participants were willing to allow me to use their material but wanted to remain anonymous. They were referred to and identified by the use of bolded initials. Those involved were my counsellor (**K**) and 'myself' (**A**) and some of 'my' alters who were also referred to by the use of bolded initials.

This study is both an extension and a progression of that research. Some of the alters who made a contribution to the MA appear again in this thesis along with some others. My counsellor will remain anonymous and continue to be referred to as **K** as will any reference to 'me', **A**. However many of the alters are now willing to be identified by name and therefore will be referred to by them, as appropriate, and also with bolded initials where quotes from tapes and transcripts are used. Any reference to other people and geographical identity will be disguised. This provides an additional layer of confidentiality over and above that already defined in the Participation-Release Agreement (see Appendix D).

Any quotations I make from notes, tapes or thoughts made in response to the taped counselling sessions will be in 'italics'.

The term Dissociative Identity Disorder will be abbreviated by the initials DID and the term Multiple Personality Disorder will be referred to as MPD. The False Memory Syndrome will be referred to as FMS.

The thesis is divided into 7 chapters in order to provide the reader with a framework by which to understand and follow the content and process. Chapter 1 is the introduction and provides the backdrop to the research. Chapter 2 introduces the reader to the field of study, namely Dissociative Identity Disorder (DID) and gives a flavour of the 'condition' and the literature and research that is around. It also explores the climate of the academic and medical debate. Chapter 3 lays out the choice of methodology and Chapter 4 introduces the alter personalities who are

integral participants. Chapters 5 and 6 look at the themes and the findings that have resulted from the study and the discussion that ensued filtering it through the traditional literature. Chapter 7 is the conclusion.

1.2.1 Reflexivity.

At this point I would like to say that as with previous research I have tried to be as open and as honest as I can about the process and about issues that have arisen around trust and rapport, the balance of power, the dynamics of the relationship and also about 'my' perceptions and hopes for the outcome of this piece of work.

McLeod's point (1994. p99) that I am the main "investigative tool" as the researcher of qualitative research remained very much in my conscious awareness throughout this study. It is because of this that I feel it is necessary to give some background to 'me' and to the alters. I was struck, too, by Rowan's observations when identifying five areas of weakness in thesis writing.

> " The first area of weakness…was the anonymity of the researchers. More often than not the reader was never told the age, colour, sex, previous experience or anything else about the researcher." (Rowan, J. 1999. p28)

It seems important to me that the reader has a good knowledge of who is taking part in the research as well as a picture of the author. I think qualitative research by its very nature requires this involvement in order that the reader has some understanding of how the participants make meaning, of and through their interactions.

Taking this on board, as both researcher and researchee in this study I will begin by giving the reader some background to the origins of this research and the participants.

1.3 RESEARCH PARTICIPANTS.

1.3.1 K. The Counsellor.

K is an accredited counsellor with the British Association for Counselling and Psychotherapy and is an experienced counsellor having been in practice for many years. He was recommended to me as someone with Christian values which at the time were of importance and pertinent as I was studying for a degree in Theology. I also felt that the problems I was encountering at that time were compounded by my strict Catholic upbringing and teaching. It was a good meeting as over the years we have unravelled and kicked into touch many of the false beliefs I was fed through the scriptures that imprisoned me, preventing what Rogers would describe as self-actualisation.

> "…the directional trend which is evident in all organic and human life – the urge to expand, extend, develop, mature – the tendency to express and activate all the capacities of the organism or self." (Rogers 1988 p351)

He has allowed me to question Church, faith and God all of which, I believe, played a part in determining my need to dissociate. Here I can put forward theories, ideas, thoughts, memories, emotions and embroider, explore, reject, experience without the uncomfortable suspicion that this man, deferentially listening, his face carefully expressionless would be thinking "For God's sake what's she thinking up now?" or "She's getting fanciful."

He is male! I think I made the choice to see him, as opposed to a female counsellor, because initially I saw that it was males who had done the damage so a male could put it right.

However it was some time into therapy when I discovered that the perpetrators of my abuse were both male and female and it was a female that had without doubt done the most psychological damage. If I am honest I saw **K** as a means to direct my anger at men not realising the difficulty I have in expressing that anger. I have over the years come to see **K** as **K**. His gender is not an issue. He is who he is.

In working with me, **K** approaches each session in a most person-centred way. He did not suggest that I had DID. He is not a counsellor who is experienced in working with DID. It was I who informed him of what was happening to me and together we have walked the path to discovery. At the beginning I was unaware that there was a name for what was happening to me let alone that it was a recognised condition. He has never encouraged the disclosure of my personalities nor indeed my story but has been attentive, believing, supportive and sensitive through some of the darkest and most painful hours. There have been times when his frustration has spilled out into our sessions and he has been unable to hide it – congruence I think is the word! There have been many times too when his compassion has filled the room; as Lord Byron said "The dew of compassion is a tear." I have never experienced him as voyeuristic or sensationalist, on the contrary, he has been utterly ethical in his practice and his respect of me, my story and my need for privacy. This is in sharp contrast to the socio-cognitive belief that DID clients are therapist tutored (Spanos 1985). He recently confided that he would have been content to live his life without the

knowledge of the things I have brought into his world but having done so is willing and committed to support for as long as it takes.

1.3.2 A. The Client, the Researcher and the Researchee.

My first memories are of abuse. As far as I can establish it began at a very early age. I have memories now as far back as two years old although there are signs that it may have begun earlier than this. There were multiple perpetrators involved, both male and female. As with a lot of experiences of sexual abuse, physical, mental and emotional abuse went hand in hand. It was sustained and covered my childhood and adolescence and reached into my young adulthood, and the effects have been lifelong.

I grew up in the Fifties as an only child with adoptive parents in a strict Catholic household. It was an era that still retained an aura of innocence. The word "incest" was never spoken and the subject of sex and pregnancy was not discussed in public or in gentile circles. Sexual abuse was not recognised or at least no one wanted to admit that it existed. It was a time before TV brought sexuality and violence into our sitting rooms. It was a time that had all the hallmarks of innocence and normality. I was educated in a convent, which I think played a strong and significant part in my dissociation. I feared the Church teachings as they ran contrary to what I was experiencing at home. I grew up confused because what I was experiencing was in total contradiction to what I was being taught at school, in church and at home. That was distressful and enough to cause a dissociation in itself. I feared - and perhaps still do fear - the concept of the traditional image of God, the father figure situated 'up there' somewhere who does not respond or react as a parent is supposed to. My

concept of 'God' has changed through the years of therapy. Perhaps this is a sign that I am beginning to believe in a right to my own opinions and beliefs. I am allowed to think for myself. Now that's an admission for 'me'.

Outwardly I was the model child. Whatever was wrong with my childhood was never apparent to anyone except me. No matter how articulate I became I was never able to voice, let alone conquer, my depression and fear, something I now realise is a direct product of abuse. It taught me the lesson that I existed at the whim of adults. I was of no consequence. I felt worthless, being treated as disposable and easily forgotten. Sometimes I thought that what they did to me was an exercise to see how far I could be degraded. Was there no depth to which I could be driven? My curiosity to see how much I could endure stopped me on many occasions from committing suicide. I'd seem to be pushed to the limits and just as I reached a limit some little voice inside said "No. If you die they win!" If a child is not loved by those who are supposed to love them how are they to ever accept that they can be loveable?

It seems to me that abused children can respond to their situation in two ways. They can shut down completely, preferring to feel nothing rather than risk the overwhelming pain and humiliation. They seek refuge in isolating activities like reading, sleeping and hiding in their bedrooms, anything to avoid the terrible reality of their life. They become passive and are seen as "well behaved" children and a "credit" to their parents. Alternatively they can resist, becoming rebellious, erratic and angry – "difficult" or "problem" children. They use their rebelliousness as a way of avoiding the reality. In effect both responses are the same. Both are used to blot out their living terrors and both permeate other areas of a child's life. My own response was the

former. No one questioned why I spent so much time on my own or why I was so unnaturally quiet. I obeyed instantly never daring to contradict for fear of the consequences. At the same time I remained hyper vigilant against danger. I switched off to feelings never crying or laughing, never screaming in response to pain. All this was done inside my head. I still do not feel the cold, except in extreme temperature. The only real outlet 'I' seemed to have was in my nightmares. It felt I was waging a war with no understanding of purpose other than my own determination to survive, but survival only led to an existence not life. I couldn't believe that things could get any worse and didn't dare hope they would get any better. This was how it was always going to be. Hope had gone. All that was left was patience.

There is no love as pure and uncomplicated as that of a child. A five year old will adore you simply because you are you. Sometimes all she needs to feel happy is the sound of your voice. At the age of five I first considered dying at my own hands. I didn't understand the concept of suicide then. I had read 'The Story of Little Black Sambo' in which the tigers had melted away to butter.

> "And the Tigers were very, very angry but still they would not let go of each other`s tails. And they were so angry that they ran round the tree, trying to eat each other up and they ran faster and faster, till they were whirling round so fast that you couldn't see their legs at all. And they still ran faster and faster and faster, till they all just melted away and there was nothing left but a great big pool of melted butter (or "ghi" as it is called in India) round the foot of the tree." (Bannerman 2003 pp51-52).

I thought if I ran long and fast enough in a circle I would melt away too.

Originally created in childhood during severe abuse experiences, my alter personalities had formed separate minds and periodically took control of the body

during extreme stress. As a young adult, I managed to escape the home and make a new life for 'myself'. I married and had children and for a long time rarely experienced stress severe enough to cause my alter personalities to surface: my symptoms were manageable and not too intrusive. For many years I blanked the experience of abuse. In choosing to wipe my mind clear I forgot what was unforgivable. It was only when studying for a degree in Theology that memories began to come back. Church and religion were triggers. Some of my memories have been corroborated but some have gone to the grave with my abusers. The revelation of the existence and the severity of the abuse brought severe emotional distress and as the memories broke into my conscious state my alter personalities began to emerge more frequently and more urgently. It was as if it was now time for them to be recognised and heard. Until now the memories of what happened had been retained only in the minds of my personalities and now they wanted to be known. Many were angry that 'I' had remained ignorant of the abuse and it's consequences for so long.

For so many years I have seen my dissociation as something to be concealed at all costs. Although as a child I didn't really consider that what I was doing was in any way unusual, - after all it took away the pain and what could possibly be wrong with that, - I had this innate sense that others would not view it in the same way. As I have grown older, coming into counselling and becoming aware of the controversy surrounding DID among the experts, I have become even more fanatical about concealing my dissociativeness. As an adult I have often questioned my sanity and the fear that others would consider me insane fed my resolve to hide this aspect of myself.

However, I now see DID as an adaptive defence mechanism to severe trauma and not a psychotic response. I had been in counselling three years before revealing it to **K**. It was an immense relief to tell him.

"He felt the enormous relief of speaking without prudence to someone who, he believed understood him….encouraged him to lay down for a short time the burden of secrecy." (Graham Greene. 'The Human Factor.)

According to Bliss (1986) and Ross (1989) it is not a condition, which the client openly displays but often carefully endeavours to conceal it. From my own experience I would concur with this view and dispute Spanos' (1985) that DID clients are attention seeking. My experience was one of secrecy and I developed ingenious ways to disguise what was going on. I never liked being the centre of attention for fear of discovery and would invent all manner of reasons or excuses to exempt myself from situations and devise and plan methods of blending into the background. I became adept at covering up my dissociation and am just considered somewhat forgetful and clumsy by family and friends but it was becoming increasingly harder to disguise what was going on. I still carry the fear that people will not believe my story but it is not stopping me any more from searching for truth and researching into the phenomenon.

Proponents of the False Memory Syndrome (FMS) (Pendergrast 1998: Spanos 1989) believe that repressed memories are manufactured by therapists and instilled into the minds of highly susceptible and vulnerable women and I can understand that this may happen. However my own experience and I'm assured the experience of many others, (Olsen 1997) was of memories being retrieved long before entering therapy. My abuse was constant and over a long period of time. I had a lot to repress. Memories began to

come back in no logical order. Once 'I' began to recall then my alters began to tell their stories. I/we remembered events where you could understand a child's need to 'split' off in order to cope. I also began to remember entire episodes of abuse and parts of others. The FMS proponents claim that such deficits in memory prove the falsity of recovered memories. However, even under the most ideal conditions memory is not linear or indeed necessarily chronological. I am amazed at the clarity of some of my memories and can add weight to the theory that the body remembers. (Goodwin & Attias 1999) My senses have been, and still are, very acute. Often when recalling an event I can remember through my senses such details as the smell of aftershave and sweat, what people were wearing, the taste of salt, the wind blowing and the leaves on the trees rustling. At first I could not understand why I did not remember in chronological order but what I now understand is that memories will return when we are emotionally able to deal with them.

Scott Peck's words sit comfortably with me,

> "We are all in need, in crisis, although most of us still seek to hide the reality of our brokenness from ourselves and one another."
> (Peck 1990. p78)

> "Oh the comfort, the inexpressible comfort of feeling safe with a person; having neither to weigh the thoughts nor measure the words, but to pour them all out just as they are chaff and grain together, knowing that a faithful hand will take and sift them, keep what is worth keeping and then with a breath of kindness blow the rest away."
> (George Eliot. 'Colonies of Heaven.' Taken from 'The Celtic Prayer Book')

It was a huge relief to be able to trust someone enough to allow them into this side of my world. It was - and still is a huge risk, but it is a relief to tell, like poison being extracted from me. I have come to realise that without these personalities I would

have been mentally, if not physically, destroyed by the depravity inflicted on me as a child. Because they inhabited the same body as 'me' we all had to learn to live and work together as a whole. It was not easy but we managed without drawing too much attention to ourselves. I think we were helped by the lack of knowledge around the subject of multiple personalities. I am more sure than ever that DID is an adaptive defence mechanism to severe trauma and not a psychotic response.

Many DID clients report having spent years in the psychiatric system being misdiagnosed and misunderstood. There are others who cope with their dissociation and may never seek therapy or help. I did not spend years in the psychiatric system myself. I came from a family who did not believe in illness or in discussing one's problems with anyone else. We were expected to cope with our own problems. Looking back I can see this was a way of hiding what was going on. However there were periods of immense despair and as a child my behaviour was often described as either 'over dramatic' or 'withdrawn' and which as a young adult drove me to attempt suicide. I was prescribed anti-depressants (which I didn't take) and warned about the consequences of not eating and sent on my way to go it alone. Fear cannot hurt you unless you surrender to it – then it can kill you.

Mollon (1996) explains that clients, whose early development has been distorted in various ways, often by the non-mirroring of the significant carer and by extensive abuse, achieve a level of functioning through the splintering of self and warding off of experiences of trauma. This way of functioning, he says, can be "unstable and deceptive" where some dissociative clients, in order to maintain a façade of functioning for a limited time, move from job to job. In maintaining this façade of

self, he says that other parts are allowed expression at other times, which can be chaotic and indeed cause havoc with integration and stability. Whilst I can understand this may be the experience of many multiples, I have always managed to maintain a good work performance, in fact holding down quite taxing and responsible jobs for many years at a time. Ross (1989) acknowledges this factor of DID. I have had changes of jobs over the years but they have been natural progressions and career moves not an attempt to hide chaos.

At present I am working as a counsellor in Primary Care and for the Psychological Services. I also have a flourishing private practice. All of my working life has been spent in the 'caring' professions. When I left school I trained as an RGN and spent twenty years nursing, ten of which were running my own nursing home. For physical health reasons, circumstances outside my control and out of personal interest I gave up nursing and decided to study for a degree in Theology and Ministry. This led to furthering my training in counselling and to working as a lay minister in a busy parish. I am a senior accredited counsellor with the British Association for Counselling and Psychotherapy and work by their code of ethics and guidelines. I have an accredited supervisor who is aware of my dissociation and monitors my practice thoroughly. Neither he nor **K** would allow me to practice if they felt there was any risk in any way. I am still in counselling.

As a counsellor I am used to facing the unique, dealing with people in their entirety. My personal counselling orientation is an integrative, person-centred approach based on the belief that counselling will be effective if it is client-centred and client-determined with direction and interventions chosen according to the client's values,

perceptions and environment, all this achieved within a trusting, accepting client-counsellor relationship.

Deciding to embark on this research led me to look at the part 'I' play. Shakespeare's line in '*As You Like It'* (2/7) .....sprang to mind, "...each man in his time plays many parts..." . In this study I am the researcher and the researchee (the client), and my 'alters' are participants. However, all constitute 'me' as the whole .

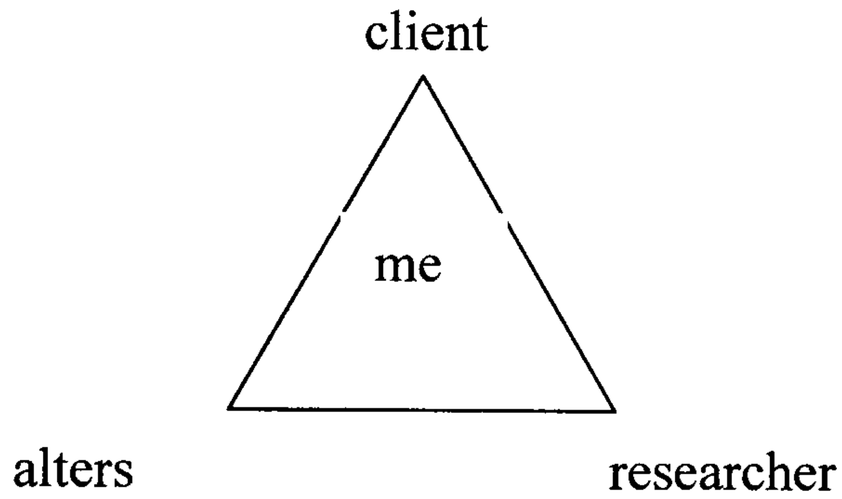


Fig 1 Dynamics of research participants

1.3.3 *The Alters*

For the ease of the reader I have chosen to introduce the alter personalities in Chapter 4 in more detail. They are integral participants of this research but for reasons that will become clearer it would be more beneficial to introduce them before the chapters containing the themes and the discussions. However it is important for the reader to have some knowledge of who is participating at this stage so I have listed them with brief detail here.

Helen, age 7yrs – female
Susie, age 11yrs – female
Emily, age 14yrs – female
Simon, age 9yrs – male
Leah, age 26yrs – female

Not only is it important for the reader to have some insight into the participants of this study but it is equally important that they have a knowledge base of the subject of the phenomena being researched. Chapter two gives an insight into the field of study.

CHAPTER 2.

THE FIELD OF STUDY.DISSOCIATIVE IDENTITY DISORDER. –

*"But it's no use now thought poor Alice 'to pretend to be two people! Why there's hardly enough of me left to make **one** respectable person'.*
(Lewis Carrol p13)

2.1. THE DID DEBATE.

"The debate is potentially humiliating to both clinicians and academic memory specialists. [what of the client/patient I ask here?] Each are faced by the realisation that their domain of knowledge is inadequate."

(Mollon 1998. pxv)

Many clinicians, as well as many of the public, are sceptical of the diagnosis of DID and downplay its validity and the numbers of people being discovered who have it (Dell 1988).

Such proponents as Gleaves 1997; Putnam 1986; Ross 1999; Bliss 1986; Kluft 1985; Mollon 1998; Spiegal 1986; Hopper 2002; claim that DID represents a psychiatric disorder with a unique and stable set of symptoms and behaviours. They believe that DID affects mainly women, although more evidence of men dissociating is coming to light, and starts early in life in children subjected to severe trauma, usually physical/sexual and emotional abuse and neglect. They claim, too, that DID is often misdiagnosed by clinicians because of the subtle and covert presentation of the disorder by patients/clients. According to Kluft (1985 pp218-219) approximately 15% of adult multiples are diagnosed when they spontaneously dissociate in the therapist's

presence; 40% show some subtle signs of DID that could alert the therapist who was aware of the diagnosis and the indicators of DID. Another 40% show no "classic signs" of DID and may be discovered accidentally or by a therapist or client who really makes an effort to figure out what is going on. If you add the 40% who show only subtle signs with the 40% who show no obvious signs, 80% of multiples already in treatment will be very difficult to diagnose and very good at concealing their symptoms. Kluft (1985) also believes that the diagnosis of DID requires

> "...no more than the presence, within an individual, of more than one structured entity with a sense of it's own existence." (p231)

and that if we stick strictly to the DSM-1V-R criteria (which requires the existence of two or more) then DID will continue to be both under diagnosed or misdiagnosed. There are several measures that can be used for diagnostic purposes. The Dissociative Experiences Scale (DES) was developed by Frank Putnam and Eve Bernstein Carlson. (see appendix A). The Divided Hearts Reading Room issued a document giving information on signs to look for in DID (see appendix B).

Whilst I agree with this school of thought, I would challenge DID as being a "psychiatric disorder" in itself. Its presence in the DSM-V suggests it is viewed as a condition needing treatment. I see it rather as being a highly developed and sophisticated method of self defence. It is an adaptive defence mechanism to severe trauma and not a psychotic response. After all, if we find ourselves in danger, it is instinctive to remove ourselves from it for self-preservation which seems to me to be the accepted thing to do. It is perhaps the ensuing internal chaos that presents the 'psychiatric' problem. My experience with working with DID clients, and of course

my own experience, is that they do not mostly present themselves for therapy because they have the personalities but because of other symptoms such as depression, self harming, eating problems, relationship issues, loss of self-esteem and self-worth that cause them a level of dysfunction. Each DID sufferer presents symptoms and behaviour patterns that have to be treated and responded to in an individual manner. Treatment is almost tailor made for each individual. With a diagnosis of schizophrenia for example, or bipolar disorder, we know that drugs and a certain regime will contain and in some cases reverse the problem. There are no drugs that will treat DID per se. Medication can help to relieve symptoms such as anti-depressants for depression but not to treat DID. Counselling and psychotherapy are the most effective courses of action.

On the other hand, the sceptics such as Aldridge-Morris, 1989; Loftus, 1995; Spanos 1985; Thigpen & Cleckley 1984; Underwager and Wakefield, 1994; Pendergrast 1998 doubt that DID exists at all except as a media or therapist induced disorder with its onset in adulthood as opposed to childhood in the trauma model.

Spanos, with several of his colleagues, conducted a series of experiments on what they call the social psychological model of DID. They believe that people can combine their knowledge of DID gained from the media with information provided by the therapist to learn symptoms of DID and with the encouragement of the therapist they can reinforce, generate and maintain those symptoms. (Spanos et al 1985: Spanos 1994). It seems to me this criticism of DID is very important as it alleges therapeutic misconduct of the gravest order. The therapist's fascination with the client's symptoms supposedly reinforces the behaviour and hence produces the syndrome.

This has never been my experience. My therapist is not an 'expert' in working with DID clients and I was unaware that what was happening to me existed as a recognised condition. In working with me, my therapist works in a very person-centred way. He did not suggest that I had DID. It was I who informed him of what was happening and together we have walked the path of discovery. He has never encouraged the disclosure of personalities or indeed my story but has remained willing to listen, believing, supportive and sensitive through some of the darkest and most painful hours. I have never experienced him as voyeuristic or sensationalist but completely ethical in his practice and respectful of me, my story and my need for privacy.

That DID is induced by medical portrayals seems to me to ignore much research and debate that has been carried out on the effects of violence seen on our television screens on both children and adults. There are media effects but they are not simple, direct identifications but cumulative and confounded by individual and situational variables (Friedlander 1993 pp66-81). Watching violence on the television is far more common than programs on the portrayal of DID, yet Spanos and other critics of DID would have us believe that the minute proportion of media time given to DID is directly responsible for the increase in DID cases.

In response to Spanos, I find myself asking several questions. "Why this disorder?" If I am so suggestible why did I not develop other disorders and why should suggestion effects be only applicable to DID? Psychiatrists and therapists ask questions and show interest in other symptoms. We do not believe that asking about eating disorders produces them in clients so why should asking about the existence of 'other personalities' or 'other parts' of the self manufacture alter personalities? The media

portrayal of mental illness in chat shows, drama and soap operas could provide me with plenty of information to develop such disorders as obsessive compulsive disorder, phobias, bipolar disorder, sexual dysfunctions and many others (all given far more coverage than DID). Why therefore don't suggestible individuals identify with these or why don't sufferers of these conditions get accused of being influenced by the media? It seems to me that DID is an adaptive defence mechanism to severe trauma and not a psychotic response.

Another criticism of Spanos and his critics (1985) is that following media acknowledgement of DID there was a sharp rise in the numbers diagnosed. The same could be pointed out for the numbers of cases of "battered baby syndrome" and of "child abuse". It also applies to other medical conditions. What media coverage can do is open a subject up and educate its listeners. It also reflects a basic process in medicine associated with the compilation and dissemination of the profiles of syndromes. Symptoms that were once unrelated can be organised into a coherent, syndromal presentation thus enabling doctors/therapists to identify the condition more often.

However, Spanos does pose an important challenge to depth psychology approaches to understanding DID. One way of excluding, in future cases, the kind of explanation Spanos offers is by eliminating the kind of iatrogenic influences from therapists which Spanos discusses and the International Society for the Study of Dissociation (ISSD) has now drawn up guidelines for treating DID in adults in order to do just that.

Gleaves (1997) argued the case for the post-traumatic model of DID criticising the sociocognitive model supported by Spanos (1994). In the post-traumatic model, development of DID begins with severe childhood trauma and as a way of coping the child dissociates into several personalities or alters. Treatment is aimed at resolving the conflicts between the various alters and possible reintegration. The sociocognitive model takes an iatrogenic approach and highly criticises psychotherapy and counselling saying that their mismanagement is the main cause of the disorder. Treatment is approached by ignoring the alters and thereby not reinforcing the behaviour. Gleaves concludes that although iatrogenic factors may play a role, DID is certainly not due to these alone. It is a genuine condition. He criticises further assumptions made by the sociocognitive model. Spanos supported the assumption that DID individuals are attention seeking and obvious in their display of symptoms by referring to the increase of supposed DID sufferers following the publication of the book 'The Three Faces of Eve' (Thigpen & Corbett 1957). Critics of this book believed that individuals were merely trying to draw attention to themselves. However, Gleaves says, this is not consistent with recent literature that reports how those with DID take great pains to conceal their condition. And this is my own experience. I have spent much of my life hiding evidence of my dissociation for many reasons - fear of being thought 'mad', fear of losing jobs through being seen as incompetent, fear of passing it on to my own children through learned behaviour. If nothing else perhaps the book gave sufferers both the courage and the permission to disclose that aspect of themselves and for the first time believe that there was help out there and that someone would be willing to listen. Attention seeking is actually lower in DID sufferers than in any other form of mental disorder and indeed, Armstrong and Loewenstein also found DID clients to be intellectual, introspective and obsessive

about privacy. (1990). According to Putnam et al (1986), studies show that there is no difference in symptoms or numbers of personalities in multiples who spontaneously reveal their DID to therapists versus those with therapists who suspected the DID before it was revealed.

It appears that the conflict between the two models centres on disagreement as to whether there are actual distinct psychological states in DID or just a number of intricate social roles. Ross (1999) identifies three basic problems in the dispute between the trauma and socio psychological models.

"a) the dispute tends to be anecdotal and ideological in nature, rather than scientific.

b) advocates of each model tend to view the two models as mutually exclusive.

c) no one has proposed a crucial experiment or piece of research that would definitely differentiate the two models, proving one and disproving the other."

(p185)

There is still no conclusive evidence that DID exists – but then neither is there any proof that it doesn't. For me, it's a little like trying to prove the existence of God – there are many theories as to why it should/could exist but there is no real, concrete evidence save the experience of individual sufferers and their testimonies, and as counsellors and therapists it seems to me that it is crucial that we respect those experiences regardless of our own beliefs. There is an interesting philosophical/language question here. DID definitely exists in some sense. The interesting point is the explanation of DID and the different explanations may not be as far apart as is sometimes assumed. Conscious, deliberate deception is one distinct

category but all else seems to occupy a similar 'family' resemblance to me. DID clients have different levels of awareness of the presence of alters, some have no recollection of an alter's presence and some have co-consciousness (i.e. they are aware of the presence of an alter but seem unable to control what is happening or being said). Even if DID has been internalised and suggested by the media in some way unless it is deliberate deception it seems to me to be a valid condition. We could say that all identity is constructed and defined from the 'outside'. The main purpose of my empirical research is not to 'prove' the existence of DID through personal testimony. This would not in any case be possible because the sceptic would remain unconvinced. The aim is to help others understand more and in turn become more open to exploring the exciting research that is currently in progress. My hope then is that therapists and clinicians will have a greater confidence to work with those with DID who seek their help. We are not as frightening as we can sometimes appear.

There are some exiting psychobiological studies of trauma-related dissociation being empirically and experimentally researched (Stein MB, Koverola C, Hanna C, Torchia MG and McClarty B 1997: Nijenhuis E 2003) which I will touch on in the section on research. Given this fact perhaps psychiatry needs to spend less time discussing the authenticity and existence of dissociative disorders and more time and money into investigating the psychobiology of the phenomena that the term 'dissociation' captures. Up till now, it seems to me also, that little effort has been invested in the study of dissociative disorders that involve such "high subjective and societal costs" (Nijenhuis 2003).

However, there are points of agreement between the two models (the socio - cognitive or the socio - psychological model and the post - traumatic model). DID is considered

to be the most complex and disabling of the dissociative disorders. Those who are diagnosed with the disorder very often experience other disorders alongside their DID, e.g. depression, suicidal ideations, eating disorders, panic disorders and have long mental health histories. People with DID do not need treatment simply because they have many different identities inside them. They need help because of the accompanying symptoms as stated. I did not seek help because of 'my' alters but because of the conflict between them and the confusion I was experiencing in a big way, all of which were causing me self-doubt, loss of confidence and a distorted view of my own humanity and right of being – all contributing to a marked disintegration of functioning.

It is known that over 90% of DID clients describe serious childhood trauma of sexual, physical and emotional abuse and describe childhoods full of chaos, loss, violence and pain (Putnam, Guroff, Silberman, Barban, & Post.1986) and this has been my experience. But in order to make sense of 'my' symptoms the past had to be faced. Both models agree that the goal is for the client not to have DID anymore and for this to happen for me, that past had to be remembered, faced, acknowledged as 'my' history and returned to 'me' and not assigned to those within me. It feels also that (and here I acknowledge this for my case in question) each alter needs to be heard, to be allowed to question, to express feelings and thoughts and in the case of the younger alters to be allowed to play, to express, to be curious – and to mature. In essence they need parenting in order for them to 'grow up'. Perhaps in 'growing up', in maturing, they and in turn 'I', can achieve integration if this is going to be beneficial. I take heart in Ross' (1999) observation that the integrated DID client is "...often healthier than the average person in our culture." DID therapy it would

seem includes a great deal of ego state therapy, which is applicable to the abnormal polypsychism, we all experience.

> "The clinical controversy centres on the disagreement about the best diagnosis and treatment plan for people who meet the DSM-1V criteria for DID. The only systematic, prospective treatment outcome data comes from the trauma model (Ellason and Ross, 1997), while advocates of the socio-cognitive [socio psychological] model have provided no data of any kind to support efficacy of their vaguely defined treatment model." (Ross 1999. p185)

Because as yet there is no hard evidence both models continue to be supported by varying evidence, which can actually support both schools of thought. Although my own experience undoubtedly leaves me supporting the trauma model, I find I am in agreement with Ross when he expresses the view that both models have validity.

> "No one from the two warring schools of thought has provided a compelling argument as to why the two schools of thought must be mutually exclusive. An alternative viewpoint is that the aetiology of DID is a mix of different influences that varies from case to case (Ross1997). According to this approach, some cases are predominantly artefacts of therapy; others have arisen in childhood, and others represent a mixture of both forms of causality".
> (Ross 1999. p185)

There are certain myths about DID that arise out of scepticism.

2.1.1 Hypnosis.

It has also been suggested that hypnosis can create multiplicity. One of the accusations made against DID is that it is therapist induced. It alleges therapeutic misconduct of the gravest order. It seems that the therapist's fascination with the client's symptoms supposedly reinforces the behaviour and therefore produces the phenomena. One of the variations of this cited is the improper use of hypnosis.

Experiments by Nicholas Spanos (1985) are sometimes used as examples of the creation of DID by role playing students. We are invited to compare the verbal responses of undergraduates responding to a staged situation with the symptoms of DID as reported in the clinical literature.

There have been two clinical studies examining the effects of using hypnosis on the symptoms and behaviours of DID clients (Putnam et al, 1986: Ross 1989) It seems there were no significant differences between DID cases diagnosed and treated with or without hypnosis. Since like myself DID appears in many clients with no history of the use of hypnotic interventions, misuse of hypnosis would appear to not be responsible for the syndrome.

Putnam et al (1986) have shown that multiples do not use autohypnosis, i.e. they do not consciously induce trances to create DID after learning hypnotic techniques from therapists. Their ability to go into trance is natural and spontaneous and an unpremeditated dissociation in response to life-threatening or perceived life-threatening situations.

With Putnam's use of client studies and Spanos' use of role-play I feel that credibility of findings belongs in Putnam's camp. Methodologically Putnam was sounder. As I see it to gain any sense of authenticity and accuracy of findings then the subjects of the research must be DID clients.

There are therapists who cautiously use hypnosis but it is not something that either **K** or I have even considered. 'I' have never been to a hypnotist. 'I' feel out of control

enough with DID without deliberately entering into a state that has, for me, a potential for further abuse.

2.1.2 Regression.

Another belief about DID could be that it is simply a regression to a child state that occurs when a client is anxious (O'Regan 1985). However, there is a difference between clinical regression and the dissociation that occurs in DID, but the difference is not always easy to distinguish. O'Regan (p22) defines regression as "a reversion to earlier behaviour patterns or modes of thinking". Generally it can be said that our emotions, perceptions, thoughts, opinions and behaviour mature as we grow older but that these can regress to earlier experiences when we are under stress or feel vulnerable. Regression exists on a continuum from mild to severe. Pathological regression occurs when we stop attending to outside stimuli and become totally immersed in ourselves. Shutting out others is seen as a disturbance of social contact (Pruyser 1981). DID, by contrast, is a disturbance of the consciousness of self.

According to Pruyser (1981) there are four characteristics of an intact self and two of these are absent in someone with DID;

a) awareness of identity, the ability to say "I am the same one that I ever was and shall be"

b) awareness of oneness, the ability to say "I am only one at each moment, for I have (or I am) an unity" (p228)

Most people dissociate at times and have experienced daydreaming and highway hypnosis but do not dissociate from themselves as those with DID do. DID begins as a response to childhood trauma and the child encapsulates and organises each resultant part of her/himself who then become personalities, with their own experiences, memories, history, function and indeed life. (Kluft 1986)

Regression allows a person to withdraw from a difficult situation. It does not create separate parts. Those with DID not only feel, think and behave like children, they *are* children when child parts (alters) are out. They behave as children in the present moment as opposed to reverting back to memory of how they were as children. DID clients very often do not remember switching or splitting and also have varying levels of awareness and communication. The personalities have their own story and history, which is associated with their time and purpose of creation. Regression is different. The people involved continue to have, and experience for themselves, one life history.

2.2. THE CONCEPT OF DISSOCIATION.

It is well over a hundred years ago now that the French psychiatrist Pierre Janet coined the word 'disaggregation' to identify changes in consciousness, which upset the normal functions/patterns of memories, thoughts, and identity that he observed in a number of his patients. Translated from French this term is now referred to as 'dissociation'. His ideas were published in his dissertation '*Psychological Automatism'* in 1889. Through his studies and observations of patients with symptoms of amnesia, fugues (loss of memory coupled with disappearance from one's usual resort) and what he described as 'successive existences' (now known as other personalities) Janet became convinced that their symptoms were as a result of detached split-off parts of the personality capable of independent thoughts, words and deeds – in other words identities.

Added to this he attributed the dissociation that caused the symptoms to past traumatic experiences concluding that these

Figure 2 'Split' off parts.

symptoms could be eased if the split-off memories and feelings could be brought into the consciousness.

Janet's work is important because it gave the first trauma-based model of dissociation. He saw traumatisation as a result from failure to take effective action against threat or potential threat, leaving the victim helpless which in turn resulted in 'vehement emotions' interfering with memory storage. Mollon (1995) explains clearly Janet's theory of memory,

> "Janet suggested that memory itself is a kind of action – the action of telling a story. This action of creating a narrative, by attaching words to the experience so that it can be made sense of, forms part of the wider action of responding appropriately to a situation. He argued (1935) 'Making intelligent sense of an unexpected challenge leads to proper adaptation and a subjective sense of calm and control' (p.409). The vehement emotions aroused by the frightening and overwhelming event prevent this process of adaptation and result in defensive dissociation. The traumatic experience is not lost from the mind, but persists as a 'subconscious fixed idea' which functions both to organise the memories of trauma and also to keep them out of awareness. Despite this attempt at mental defence, these highly emotionally charged 'fixed ideas' containing the memories continue to affect perception, mood and behaviour. The person behaves 'automatically' according to images and perceptions and emotions derived from the past rather than realistic assessment of the present." (p37)

This certainly bears out my own experiences whereby triggers, whether external in the form of my senses such as smell and sound or internal such as feelings and emotions, initiate responses that come into automatic play and have not been thought through. For years there were times when I could not understand where these automatic responses were rooted and what caused them. Dissociation was/is my automatic response to fear. Mollon goes on to say that

> "Janet thought that for adaptation to trauma it was necessary for a person to be able to talk to themselves and others about it, to form a narrative: 'It is not enough just to

> be aware of memory; it is also necessary that the personal perception "knows" this image and attaches it to other images' (Janet 1909b. p1557)"

My question here is, 'Is this not exactly what is happening in dissociation?' In the face of an overwhelming event and no one else at hand to have this narrative with, does the 'core' personality create the 'alters' to "talk" to and to experience the overwhelming pain in order to adapt to the trauma thereby both protecting his/her psyche and surviving? Janet also postulated that memory is a creative act in which we organise and categorise our experiences in order to assimilate them into existing structures. Is this not what a multiple personality does; only instead of categorising their experiences in one 'core' mind, they split their experiences into different personalities in order to assimilate them? When a child is being abused it is usually done in 'secret' and 'behind closed doors'. It is usually done out of reach of the possibility of entering into a narrative with another person in order to adapt to the situation. When the abuse is isolated, systematic and sustained another path to adaptation has to be made and the narrative is created with 'alter personalities' – hence dissociation.

Janet saw the 'narratisation' of experiences as being disrupted by dissociation. He saw dissociation as a 'narrowing of consciousness' whereby experiences cannot be associated with each other so that thinking cannot occur (Mollon 1995). 'My' experience here is somewhat of a paradox. I acknowledge that in dissociating 'I' did not allow 'myself' to think. 'I' divorced 'myself' from the situation at hand thereby 'narrowing my consciousness' but listening to the alters on the tapes it is apparent that thinking did occur by the alters and they are now only too ready to ask their questions

of **K** as in this dialogue between **K** and **Susie** (age 7yrs) shows. (**Susie** had been relating an incident with her mother)

S. Is my mummy bad?
K. Pardon?
S. Is my mummy bad?
K. You mean… your mummy at home?….What do you think Susie?
S. Mummies are not supposed to be bad.
K. No. They're not. You're right. Is your mummy bad?
S. I don't like her very much.
K. You don't like her very much….Is she bad?….Is she bad?…….OK…I believe you….If you say to me that your mummy's bad then I believe you.

(Tape 12)

A little later on **Susie** asks another question. Again she had been relating an incident involving her mother and her pet canary

S. I picked my canary up…once and it squeaked…
K. Uh huh.
S. …and my mummy hit me…She said we're not supposed to make things hurt….I was cruel….I didn't mean to. I just picked it up too …(deep sigh)…too tight.
K. You didn't mean to hurt it….but they're very cruel to you aren't they…and they make you hurt?
S. So why can they hurt me and I can't hurt……

(Tape 12)

At the time there was no one to 'narratise' with but it would appear that thinking in a sense did not stop just went underground. Now, in therapy that thinking can emerge through the alters to the surface and can be faced by 'me'. In recording the sessions 'I' can listen to these personalities and their thinking can be brought into 'my' consciousness. I am unaware as yet of any research or explanation into the concept of this.

Mollon (1996) gives the example of a patient, whose multiple personality had been partially resolved in therapy, who had difficulty in thinking. He describes her as only being able to "…'see' the surface of whatever was in the forefront of her mind: she could not look beyond this or 'into' this without help from the therapist." It appeared that her dissociated pieces of experience "…formed isolated cores of consciousness, taking turns to emerge into the foreground of awareness, and which did not communicate with each other so that experience could not be thought about." There have been times when this has caused me problems and I struggle to make sense of my perceptions and beliefs particularly around what 'I' saw as my responsibility in the abuse. I could not at times rationalise where they have formed or come from. I am still sometimes unable to look beyond what is in 'my' consciousness at a given time. It is here that the use of audiotapes in counselling sessions has been invaluable as I can revisit sessions and coupled with my therapist's ability to track what I have said I can begin to make connections. There are times when thinking is difficult but listening to the interaction that **K** has with 'my' personalities 'I' can make those connections. It would appear that 'my' personalities have a good ability to think and to process information. They, too, are able to debate, to reason and to rationalise with **K**. They can ask questions, hear explanations and receive validation. It feels, for 'me', that the whole counselling process and the involvement for them is in a sense 'growing them up', particularly the younger alters. Instead of remaining stuck in their time and beliefs and perceptions, they are being educated and are receiving the parenting that was sadly lacking, bringing them to a sense of maturity.

A. (sounding upset)…Um….having listened to some of the tapes with Helen and the others….it feels as though sometimes ……what is going on is….you are doing the job that maybe my parents should have done…..
K. Mmm.

A. …in….um….it's almost as if this process is…..helping them grow up….Does that make sense?
K. Uh huh…..Yes….I can accept that….I mean this is what…..it seems to me with Helen here we have a seven year old child asking basic questions.
A. I could never have asked my mother…I mean I don't ever remember asking….I don't ever remember um……
K. I mean it's very much a child phrasing the questions….putting the questions…
(Tape 72)

Janet's conclusion that dissociation takes place as a mental defence against anxiety fits with my own experience of survival. In order to safeguard my sanity and at times my life, it was necessary for me to develop some form of protection. The protection was not forthcoming from anyone else. He believed that memories are stored at various levels for processing, as sensory perceptions, visual images, stories and if these memories are stored at levels less than narratives then they can return intrusively and disconnected with what is the current reality – known as 'flashbacks'.

Janet's work was followed a few years later by Freud and Breuer (1893-95) in *Studies of Hysteria*. Both European and American contemporaries of Janet expanded upon his work and a model for diagnosis and treatment was built.

It was during the 1930's, when the psychiatric profession took on board Freud's theories that interest in the study in dissociation declined. Following the '*Studies of Hysteria*' Freud concentrated on the concept of repression and the innate conflicts of the mind especially the Oedipus complex. Freud wrote several papers discussing repression of an instinct and an idea and also repression of various other mental contents. His theme was a sexual one. Repressed sexuality, the unconscious denial of a forbidden and now forgotten sexual wish or experience, seemed to him to be a fundamental cause of the great majority of neuroses which he had encountered. He

turned away from a trauma-based model of psychology (although not entirely dismissing it) towards a more innate, more instinctive, programmed conflict. As Mollon says

> "The concept of repression applies well to a theory of instinctual conflict. but less well to a theory of trauma. 'Repression' implies a mastery of an instinct by pushing it back down from whence it comes, whereas 'dissociation' implies an attempt to escape from some unbearable situation by denying, through a kind of pretence, that one is present." (1996. p36)

In 1970 Ellenberger put dissociation into the realm of academia and in the 1980's it became officially recognised by the psychiatric fraternity. In 1980 the Diagnostic and Statistical Manual-111(DSM-111) introduced the diagnosis of dissociation and in 1984 the International Society for the Study of Multiple Personality and Dissociation (ISSD) was founded. During the 1980's an awareness, both publicly and professionally, of child abuse and the steep rise in treatment of Vietnam War veterans' post traumatic stress syndromes brought about a renewed interest among professionals.

More recently, 2002, the UK Society for the Study of Dissociation (UKSSD) has been relaunched after a two-year break. It was initially founded in 1994 as a component society of the ISSD.

Currently the Victims of Violence and Abuse Prevention Programme (VVAP) is being established in partnership with the Home Office. Professor Cathy Ilzin is running the programme and four other expert groups are being set up:-

- Domestic Violence and Perpetrators

- Child Victims of Domestic Violence and Child Sexual Abuse
- Adolescent and Adult Sex Abusers/Offenders
- Adult Rape and Sexual Assault

2.2.1. Dissociative States.

The Diagnostic and Statistical Manual – fourth edition (DSM-1V) published by the American Psychiatric Association identifies four dissociative disorder groups. Dissociative disorders are a group of psychiatric conditions, which share certain common features, not as yet understood to be due to an organic mental disorder or any other disorder.

2.2.1 [a] ***dissociative amnesia***.-(psychogenic amnesia)

-which is sudden inability to recall important personal information too extensive to be explained by ordinary forgetfulness. It does not occur exclusively during the course of another mental disorder and is not as a result of the effects of a substance or neurological/medical condition. (adapted from DSM-1V pp478-481)

2.2.1 [b] ***dissociative fugue***.- (psychogenic fugue)

-which is sudden unexpected travel away from one's home or work place with the assumption of a new identity and the inability to remember one`s past. This does not occur exclusively during the course of DID and is not as a result of the effects of substance or medical condition. It is usually related to traumatic, overwhelming life events (adapted from DSM-1V, pp481-483).

2.2.1 [c] ***depersonalisation disorder***.

-which is persistent or recurrent episodes of depersonalisation (in which the usual sense of one's reality is lost or changed) sufficiently severe to cause marked distress. It too, does not occur exclusively as the result of another mental or medical condition (adapted from DSM-1V, p490).

2.2.1[d] ***dissociative identity disorder***. (DID)- (multiple personality disorder)

-"…characterised by the presence of two or more distinct personalities or personality states that recurrently take control of the individual`s behaviour, accompanied by the inability to recall important information that is too extensive to be explained by ordinary forgetfulness." (DSM-1V, p487)

The current version of the manual adds two more qualifying characteristics in an effort to clearly define the disorder and hence limit the possibility of misdiagnosis.

" The disturbance is not due to the direct physiological effects (e.g. blackouts or chaotic behaviour during alcohol intoxication) or general medical condition (e.g. complex partial seizures)."

"In children the symptoms are not imaginary playmates or other fantasy play."

There are a group of clients who show some degree of dissociative symptoms but who fall short of the criteria listed above. These can be described as suffering from Dissociative Disorder Not Otherwise Specified (Cohen et al 1991).

However, there is some exciting research being done to try to give tangible credence to dissociation. There has been a study by Murray B Stein at UC San Diego (1997) in which magnetic resonance images of the brains of 20 women with histories of prolonged abuse have been observed. The size of the hippocampus was found to be significantly smaller in the women with abuse histories. It was also found that among these women those with the smallest hippocampal volume had the highest scores on a standard test for dissociation. It is an exciting field of research and may hold the key to belief and credibility for someone like myself.

[information taken from the internet. Bower, 1995]

2.3. HOW DOES IT START? – ITS ROOTS IN CHILDHOOD.

Roses are red.
Violets are blue.
A face like yours
should be seen in the zoo.

This was the first rhyme I learned. I was about three years old. My mother would repeat it to me over and over again.

It is generally accepted that dissociation has its roots in childhood and that DID arises in childhood mostly between the ages of 3 to 9 years.

> "Current mainstream thinking on the aetiology of MPD [DID] is summarised in the four-factor theory (Kluft,1984a). This theory holds that the individual who will develop MPD has the capacity to dissociate (factor 1), and is subject to sufficient exogenous stressors that his or her non-dissociative defences and coping resources are overwhelmed (factor 2). (In contemporary American society, the usual source of these stressors is child abuse, reported by 97 to 98 percent of contemporary MPD patients [Putnam et al., 1986: Schultz et al., 1989].) The mind uses any number of available substrates to serve the nidus of personality formation (factor 3). In the absence of soothing, protection from additional traumata, and the opportunity to process and metabolise the traumatic material (factor 4). the dissociative adaptation

is reinforced, becomes relatively fixed, and may become further elaborated. In my series of patients, there was no inevitable association of trauma within a particular developmental stage and an MPD outcome, but clear indications that developmental considerations influenced the conflicts embodied in the several alters. The prevailing wisdom in the field is that it is unlikely that a neurologically normal child who has reached the age of eight or nine without suffering severe trauma will develop MPD. There is a fledgling literature on MPD in children (reviewed in Kluft, 1986); the youngest documented case is in a three-year-old girl (Riley & Mead, 1988).

(Kluft R. 1985).

Valerie Sinason (2002) asks the question

> "What happens when a child has to breathe in mocking words each day? What happens when a parent, an attachment figure utters those words: someone the child needs in order to emotionally survive?" (p4).

Here she seems to be relating to Kluft's factor 4.

In her answer

> "Sometimes, that mocking voice gets taken inside and finds a home. It then stays hurting and corroding on the inside when the original source of that cruelty might long ago have disappeared or died." (p4).

she is connecting to Kluft's factor 3.

She goes on to ask

> "What happens when the toxic nature of what is poured into the undeveloped? vulnerable brain of a small child is so poisonous that it is too much to manage?

clearly relating factor 2.

Mollon (1996) says,

> "Dissociation involves an attempt to deny that an unbearable situation is happening or that the person is present in that situation. Thus dissociation involves the defence of denial, but in addition requires a degree of detachment of part of the mind from what another part is experiencing." (p4)

It seems that many contemporary clinical theorists (Putnam 1986: Kluft 1985: Gleaves 1997: Herman 1998.) studying the psychological effects of trauma contend that early traumatic childhood events lead to the repeated use of dissociation until it becomes the child's primary psychological defence. which they carry then into adulthood. This dissociation manifests itself in alterations in the experience and perception of self and the world. (Kluft 1985: Putnam et al 1986). These models define a causal continuity between childhood trauma and the subsequent dissociation of adulthood and this causal link is fundamental to how these theorists explain and therefore treat dissociation.

It could be said that there is evidence against trauma as a cause for dissociation (Kendal-Tackett, Williams, Finklehor,1993). Many people suffer trauma but do not resort to dissociation and perhaps there are those who would question that childhood sexual abuse is by definition traumatic. According to Kluft's four-factor theory, a child who has an extensive ability to dissociate is subjected to overwhelming and repeated trauma. 97% of multiples have a history of trauma that includes chronic and severe physical, emotional and/or sexual abuse (Putnam, Guroff, Silberman, Barban and Post 1986). In some cases the trauma may have been non-abusive such as a near fatal accident or the death of a parent or divorce. The definitive factor for trauma, it seems to me, is the presence of overwhelming and extreme anxiety. Kluft's theory

(fourth factor) also states that a child who dissociates is without resources that could change the situation, provide safety and support or give the child the opportunity to process the trauma. In the absence of safety the child resorts to the only coping skill at his/her disposal.

Lazarus (1999) distinguishes between stress and trauma

> "In common-or-garden stress, the person is able to cope without falling apart or developing serious symptoms of adaptational struggle. The person is "whelmed" so to speak, but not "overwhelmed", but this is always a matter of degree. When people are traumatised, however, they are overwhelmed, which means being unable to function without substantial help, possibly only temporarily, though the dysfunction could continue indefinitely." (p129).

In the face of overwhelming anxiety/trauma and no resources to change the situation, the child uses its coping skills of dissociation.

Having defined trauma as being in an overwhelmed state, how then do we distinguish between being "whelmed" and overwhelmed? Lasarus (1999) sees the essence of trauma as "…that crucial meanings have been undermined" (p129). These meanings, he says, have to do with

> "..feelings of unworthiness, the belief that one is not loved or cared about and perhaps the most important, people who are traumatised no longer believe they are able to manifest any control over their lives. The fundamental meanings that once sustained traumatised persons – in effect their very reason for living – have not been just threatened or challenged, as in most stressful transactions, but severely damaged or destroyed by the traumatic event." (p129)

I can remember being in this position as a child, reaching the point where all hope had gone and only patience remained. Dissociation seems to me to be a response to that destruction.

In 1993 Kendal-Tackett, Williams and Finkelhor went further and questioned whether all cases of sexual abuse necessarily involved overwhelming affect, fear for safety and helplessness. My own belief here is that not all sexual abuse, or any other abuse, necessarily produces all of these states. Many factors other than the act of abuse itself have to be taken into consideration, the relationship of the perpetrator to the child, the nature of the abuse, the location of the abuse, the length of time the abuse was over, what was involved and the innate psychological strength of the child. What is experienced as traumatic for one person may not be seen as such to another. My own experiences of these factors in my abuse led me to know when my safety was threatened. There were times when, although not liking what was happening, I knew my life/existence was not in danger and at other times I did not know whether I would survive the ordeal. I learned at a very early age to discern the difference. Neither, however, stopped me feeling out of control and helpless. In the end to dissociate at any hint of abuse was the safest thing to do. Some occasions were more traumatic than others. Often just the anticipation of abuse was traumatic in itself. The longer it went on the more 'overwhelmed' I became and steps had to be taken to psychologically and physically survive. For me, abuse was traumatic. It was both a physical and a psychological shock, which has had a lasting effect on my subconscious and ability to function.

In terms of dissociation the cause or the reason for it has been theorised as related to the individual's survival (Spiegal 1986) and this certainly was the case for me when it was happening. However it is argued that the continued use of dissociating must also have a purpose. After all, why continue to dissociate after the trauma has ceased? I can only speak for myself here and liken it to driving a car. After years of changing gears whilst driving it becomes an automatic response, one you become unaware of performing. The manoeuvres taken on board when a learner, become second nature with use and automatically come into play when needed, emergency stops, three point turns. It seems to me to be the same with dissociation. When faced with overwhelming feelings and events it kicks in as an automatic response. As a defence mechanism it was second to none. What may have been a suitable response to a situation as a child may not be so for an adult but as therapists if we dismantle a coping mechanism that has been in place for years we must replace it with one equally as efficient and acceptable to the client. This might mean partial or total integration and the client being able to face future crisis as 'themselves' without resorting to dissociation or it may mean the client learning to live in harmony with their alters.

There have been studies, which have identified a link between childhood abuse and dissociatio.(Putnam 1991). One of the most notorious cases that demonstrated this connection was that of Sybil as reported by the psychiatrist Dr C Wilbur in 1974 in the book ' S*ybil* ' by Schreiber (1975). In 1982 Confer and Ables reported the case of Rene.

In 1984 Finklehor estimated that 150,000 to 200,000 new cases of child sexual abuse were being reported yearly, showing that increasing numbers of children are reporting

experiencing early traumatic life events during critical periods of personal development.

1986 saw the National Institute of Mental Health conduct a survey, which reported that 97% of 100 cases recalled being subjected to severe child abuse.

1986 again, saw Coons and Milstein conclude that 75% of 20 DID cases recalled severe sexual abuse and 50% had a history of physical abuse as children.

I do not think that many would dispute that violent or sexual episodes have a direct effect on the psychological, emotional, cognitive and interpersonal development of the child. Raise a hand to a child who is used to being beaten and watch him flinch or cower. Watch a child who has been subjected to negative criticism and see how reluctant she is to offer thoughts or opinions. Observe a child unused to playing with toys or other children and notice how they remain on the sidelines unable to interact. How often do children who have been exposed to sexual behaviour go on to inappropriately express themselves sexually? The long-term effects can manifest themselves in many ways too, - in aggression or passivity, in an inability to respond emotionally, in memory loss and in increased frequency of dissociative responses.

According to Brier dissociation is a frequent symptom of victims of child sexual abuse. He reported in his clinics that victims disproportionately reported symptoms of dissociation.

42% v 22% non-victim- dissociation and 'spaciness'

21% v 8% - non-victim- 'out of body experiences'

33% v 11% - non-victim- sensation that things are unreal

Working with Runtz in 1985 he also reported that out of a student example sexual abuse victims scored significantly higher on the Dissociation Scale. As a result they formed the hypothesis that dissociation is a strategy/defence mechanism to escape or cope with the unpleasant feelings of the abuse and that this later becomes an autonomous symptom (Brier, J. & Runtz, M. 1985).

In 1991 the Canadian Journal of Psychiatry published the findings of research by Colin Ross and his colleagues in the abuse histories of 102 cases of DID. These individuals were interviewed at four different centres using the Dissociative Disorders Interview Schedule. The patients reported high rates of childhood trauma.

90.2% had been sexually abused

82.4% had been physically abused

95.1% subjected to one or both forms of abuse

Over 50% reported initial physical and sexual abuse before the age of 5yrs.

The average duration of both types of abuse was ten years.

Numerous different perpetrators were identified

Subjects were equally likely to be abused by their fathers or their mothers

Sexual abusers were more often male than female but a substantial amount of sexual abuse was perpetrated by mothers, female relatives and other females.

Their findings seem to suggest that DID is a response to chronic trauma originating during a vulnerable period in childhood (Ross, et al 1991).

There are other symptoms/behaviours associated with severe sexual abuse – nightmares, phobias, compulsive behaviours, self-harm, inordinate sexual behaviour and sexual abuse has a high connection with post-traumatic stress disorder leading to more extreme disturbances in 'object relations'. According to Putnam (1989) it is the culmination of these stressors, which form the chronic, complex, DID or other dissociative disorders. He concluded that sexual abuse was a factor of DID because of large numbers of cases, which involved severe and often brutal physical and sexual abuse in childhood including incest.

2.3.1. How I Dissociated.

Much of my childhood was spent in isolation. I was forever being 'punished' for some offence or another, which often meant being banished out of sight. I spent many hours, sometimes days, in my bedroom. It was often quoted to me (and indeed given to me in a book of rhymes as a small girl)

'Father heard his children scream
So he threw them in the stream,
Saying, as he drowned the third,
"Children should be seen not heard."
(The Stern Parent. From 'Ruthless Rhymes for Ruthless Homes' by Harry Graham).

It was an edict that pervaded all my young years into adulthood. I was to be seen and not heard to the point that no words or expression of emotions were to be heard. I was

to ask no questions nor offer any opinions. These emotions had to have an outlet somewhere.

In his recent memoir, 'The Child That Books Built', Francis Spufford (2002) vividly describes the way reading furnishes children with a space in which to live – a parallel universe that allows them simultaneously to escape from and make sense of the real world. His description of his escape into books perfectly echoes my own experience. He says,

> "There's a special silence, a reading silence. I never heard it, this extra degree of hush that somehow travelled through walls and ceilings to announce that my seven year-old self had become about as absent as a present person could be. The silence went both ways. As my concentration on the story in my hands took hold, all sounds faded away. My ears closed. I didn't imagine the process of the cut-off like a shutter dropping, or as a narrowing of the pink canals leading inside, each waxy cartilaginous passage rising tight like some deft alien doorway in Star Trek. It seemed more hydraulic than that. Deep in the mysterious ductwork an adjustment had taken place with the least possible actual movement, an adjustment chiefly of pressure. There was an airlock in there. It sealed to the outside so that it could open to the inside. The silences that fell on the noises of people and traffic and dogs allowed an inner door to open to the book's data, its script of sound. There was a brief stage of transition in between, when I'd hear the text's soundtrack poking through the fabric of the house's real murmur, like the moment of passage on the edge of sleep where your legs jerk as your mind switches over from instructing solid limbs to governing the phantom body which runs and dances in dreams. Then, flat on my front with my chin in my hands or curled in a chair like a prawn, I'd be gone. I didn't hear doorbells ring, I didn't hear suppertime called, I didn't notice footsteps approaching of the adult who came to retrieve me." (p1)

Moving into a book was like walking through the wardrobe door in The Chronicles of Narnia.

As a child I learned to read at a very early age even before going to formal school. Books always held a fascination for me – and still do. Looking at the pictures in the

'Janet and John' books I made connections with them to the words underneath. I spent many long hours in my room keeping out of the way of my parents and others.

Reading fairy stories taught me my station in life. In fairy tales character is destiny. Who the people are and what happens to them are completely inseparable. You can predict what will happen to a good princess purely from the fact that she is a good princess. The same applies to the bad princess. Their identity in a story maps out their future. I was so often told how bad I was or useless that I saw the destiny of the 'bad princess' as mine. My only hope, no – wish – was that the fate of the wicked step-mother would befall my mother. The longed for hope of a fairy godmother never materialised, after all, I was not Cinderella I was an ugly sister.

As a very young child I would imagine myself living inside my dolls house. I would imagine the characters from Enid Blyton's 'Mary Mouse' stories (they too lived in a dolls house) being my family and looking after me. I could be - and do - as I pleased in this house. This was my nurturing that was missing in my real life. (Tape 78)

A…and I started to play with….I had this ritual you see before I went to bed. I used to pull all the curtains…all the little curtains …and I used to pull all the curtains along..
K. In the doll's house?
A. Mmm…I used to imagine them all tucked up in bed.
K.Mmm. Were you allowed to pull the curtains…draw them not pull them altogether …I mean in your bedroom?….You weren't?
A. I wasn't allowed to touch anything.
K. So did you sleep with the curtains open?
A. Sometimes…
K. Who decided?
A. My mother…(silence)…Sometimes she would open the windows….wide…
(Tape 78)

Before long I was reading the Enid Blyton books and becoming so engrossed I could imagine myself as part of the story and plot. I was able to transport myself into the book and would become the 'famous sixth' or the 'secret eighth'. I had a part to play in them that wasn't the butt of others abuse. As Spufford (2002) describes so eloquently I was able to become oblivious to all around. It was effective in removing me from the pain of the reality of my life and gave me some respite. Fantasy gave me a taste of what reality should have felt like.

Alice, out of '*Alice in Wonderland'* was a character I could so identify with. She was often never sure who she was.

> "Dear, dear!. How queer everything is today! And yesterday things went on just as usual, I wonder if I've changed in the night? Let me think: was I the same when I got up this morning? I almost think I can remember feeling a little different. But if I'm not the same, the next question is "Who in the world am I?" Ah that's the great puzzle! And she began thinking over all the children she knew that were the same age as herself, to see if she could have been changed for any of them…….but her voice sounded hoarse and strange, and the words did not come the same as they used to." (p15).

Later, when asked by the Caterpillar "Who are you?" she replies

> "I – I hardly know, Sir, just at present – at least I know who I was when I got up this morning, but I think I must have changed several times since then. What do you mean by that?' said the Caterpillar sternly. 'Explain yourself!' 'I can't explain myself , I'm afraid, Sir' said Alice, 'because I'm not myself you see.' 'I don't see' said the Caterpillar. 'I'm afraid I can't put it more clearly,' Alice replied, very politely, 'for I can't understand it myself, to begin with; and being so many different sizes in a day is very confusing. 'It isn't' said the Caterpillar. 'Well perhaps you haven't found it so yet,' said Alice; 'but when you have to turn into a chrysalis ….and then after that into a butterfly, I should think you'll feel it a little queer, won't you?' 'Not a bit,' said the caterpillar. 'Well, perhaps your feelings may be different,' said Alice: 'all I know is, it would feel very queer to me.' 'You!' said the Caterpillar contemptuously. 'Who are you?' (p31)

It didn't take long to realise how effective losing oneself in fiction was and to progressing to 'leaving' in my head at the sign of abuse or anticipation of that abuse. I learned to adapt this ability of transporting myself into a story, to putting myself into a safe place of my own. Sometimes that meant removing 'me' from my body and watching from a safe distance what was happening to me. It seems that this quickly progressed to disconnecting 'me' from what was happening to the physical being below and denying connection. This was totally someone else. The different abuse experiences and the different

Fig. 3 Out of Body experience

situations I was subjected to seemed to require a multiformity of 'people' to protect 'me' and 'my' psyche. Hence the birth of alters. These new personalities deserved to de identified. They were performing a life saving service and deserved to be recognised. Eventually this became an automatic, unconscious action in the face of fear, a fear that has evolved and developed over the years.

2.4.RESEARCH.

Areas of research are ever expanding in the field of dissociation and DID. There is a great wealth of material and literature from the 'experts'. There are vast quantities of literature pertaining to the aetiology, the recommended and the not so recommended treatments, expected outcomes, the validity of the condition, its frequency, its prominence in women and its growing existence in men. (Cohen, Gillier, & Lynn,1991: Coons,1986:Kluft,1985:Loewenstein,&Putnam,1990.Ross,1997: Sinason,

2002: Mollon, 1996:) Is it related to trauma and if so what is the definition of trauma? The discussions are endless. They provided me with statistics, models, hypotheses and findings and gave me an insight into the turbulent world of the debate on the validity of the condition.

In recent years great steps have been made in the area of psychobiological research. In 2001 Vedat Sar, Professor of Psychiatry at Istanbul University and his colleagues published a brain perfusion study. Using SPECT, Single Photon Emission Computed Tomography, they found less cerebral blood flow in the orbitofrontal cortex, bilaterally, more flow in the left temporal lobe in patients with DID. The orbitofrontal cortex is essentially involved in the regulation of affect, behaviour, the autonomic nervous system, motivational states and homeostasis (Schore,1994) and is also important in the recall of emotional memories (Markowitsch, 1999) and in attachment (Schore, 1994).

> "Maturation of the orbitofrontal cortex may account for the infant's ability to tolerate higher levels of arousal and stimulation, and reduced activation in the area may relate to living with a small window of stress tolerance" (Nijenhuis et al 2003)

Stein, Koverola, Hanna, Torchia and McClarty (1997) conducted some research in which magnetic resonance images of the brains of 20 women with histories of prolonged abuse were studied. The size of the hippocampus was found to be significantly smaller in the women with abuse histories compared to the controls. It was also found that among these women those with the smallest hippocampal volume had the highest scores on a standard test for dissociation. but not with indices of explicit memory functioning. Therefore it seems that the relationship between hippocampal volume and memory functioning may be mediated by dissociation.

Further study it seems is necessary to discover if smaller hippocampi constitute a premorbid risk factor for post-traumatic stress disorder (PTSD) and the DSM-1V dissociative disorders or if they are caused by chronic exposure to stress. However, Bonne (2001) reported that a smaller hippocampal volume was not a necessary risk factor for PTSD.

Nijenhuis (2003) and his colleagues have tested psychobiological differences between dissociated parts of the personality engaging in functions of daily life and parts engaging in defensive reactions to perceived threat in women with DID. They address these parts as apparently normal and emotional parts of the personality respectively (ANP and EP). When exposed to neutral episodic memories, autobiographical for ANP as well as EP, no differences emerged in terms of subjective responses, psycho physiological responses, and regional cerebral blood flow patterns (rCBF). However when exposed to trauma scripts (90 sec) only autobiographical for EP (i.e., ANP did not regard the relevant memory as a personal memory) large differences manifested, subjectively (sensorimotor and emotional reactions), physiologically (compared to baseline and to ANP, EP had increased heart rate, frequency, increased systolic blood pressure and decreased heart rate variability) and very different rCBF patterns (Reinders, Nijenhuis, Quak et al., in preparation).

They also tested ANP's and EP's reactivity to subliminally presented threat cues (angry faces), less threatening cues (anxious faces) and neutral cues (neutral face expressions). In this experiment they also included controls instructed to role play ANP and EP. They found statistically significant differences between performance of the patients and the controls for their responses to angry faces as compared to neutral

faces. The study suggested that role playing controls did not succeed in copying the performance of DID patients, and that ANP and EP have different responses not just to supraliminal but to subliminal threat cues. (Van Honk, Nijenhuis. Van der Hart.. in preparation). To some extent the results have been described by Nijenhuis. Van der Hart and Steele (2002).

The use of MRI and PET scans (Nijenhuis, 2003; Debellis, 1999; Bessel & Van der Kolk,1994 and 1996) continues to provide psychobiological research with scientific information which could help to resolve the dispute between the sociocognitive and post-traumatic schools of thought. This would be an enormous comfort for those of us who find it difficult to reveal our DID status for fear of disbelief, ridicule or rejection. Nijenhuis (in preparation) concludes that his

> "...reviewed studies reveal that the psychobiology of trauma-related dissociation can be studied empirically and experimentally and that these studies generate important knowledge and insights.....The evidence suggests that patients with dissociative disorders have structurally and functionally abnormal brains, and that they operate in insufficiently integrated psychobiological modes across time. Trauma-related dissociation does not divide the personality in accidental ways. It rather seems that structural trauma-related dissociation of the personality reflects a lack of integration among psychobiological structures that are driven by certain action systems. The primary form of this structural dissociation involves failed integration between parts of the personality dedicated to daily life and survival of the species, and parts that are dedicated to the survival of the individual in the face of severe threat."

What ever we think of the theory of structural dissociation of the personality it offers specific and testable hypotheses. However, it leaves me with a few questions. Can the brain be schooled/trained/in someway made to function 'normally' again? What are the implications for both the client, in terms of what to expect/prognosis/outcome, and the therapist, in terms of approaching the therapy? How much too, can the client be held responsible then for their actions/behaviour/approach to life/perceptions/beliefs?

All this sophistication of information is of immeasurable importance to those who suffer from the condition and to those who help and treat them but for me it feels very clinical. It seemed to me that, as both a sufferer and a therapist, there was something vitally missing. It was all from the eyes of the clinicians and the psychologists. In searching for studies that might give me something to use as a yardstick, I was pointed to the ISSD's extensive bibliography, which runs to 181 pages. The bibliography seems to have less than 20 references involving some form of phenomenological exploration. In the last three years the 'Journal of Dissociation and Trauma' has printed 15 articles describing research involving from 1 (case reports) to 46 clients manifesting DID but there did not appear to be any based specifically on phenomenological methodology. There is no actual research that I can unearth that has been conducted from the eye of the client and certainly none that could give me an insight as to what feelings I could expect to experience and their effect.

I found some books written by multiples chronicling their experiences of being multiple and how their treatment programmes affected them, e.g. 'First Person Plural' by Cameron West, 'The Flock' by Joan Frances Casey, 'When Rabbit Howls' by 'The Troops for Truddi Chase' These books tended to tell the authors' stories, the practicalities of living with DID and the effects on surrounding relationships. They occasionally gave insights into how the authors felt at times but there were no in-depth exploration as to why they should have these feelings or if indeed they were 'their' own emotions or those of their alters. They were not research based in that there was no systematic gathering of data.

There are some accounts from clients used to illustrate theories and points in books written by clinicians. These clinical vignettes are also valuable. Jennifer Anthony-Black as co-editor with Moira Walker, has contributed to a series of essays in *'Hidden Selves'*(1999) in which the authors respond to a narrative by 'Lisa' a woman who describes her story and experience of being dissociative. Each author describes how s/he would work with Lisa and some give their views on dissociation. Anthony-Black reveals that she is herself dissociative and is a practising counsellor. She has set up the Quetzal Project in Leicester, - a voluntary organisation which provides counselling for women survivors of sexual abuse. Neither Lisa nor Anthony-Black overtly reveal how being dissociative has felt for them or how they do or do not express those feelings.

There are several web sites on the Internet for people to go to for information and also to contribute to. Many sufferers have written moving poems and stories and have submitted drawings, sketches and paintings, which give some indication of the level of feelings around for the dissociative client.

In 1997 an audit was undertaken using the Dissociative Experience Scale (DES) (see appendix A) among all the inpatients at a Norwich Psychiatric Hospital. A standard instrument on a single day to measure the point prevalence of dissociative symptoms experienced by all of the acute psychiatric inpatients in a modern unit of 120 beds, was applied. All the patients had received standard diagnosis and treatment. The findings were significant. The patients admitted to the acute psychiatric unit clearly presented dissociative behaviours but, within a culture unaware of this phenomenon, they remained undiagnosed. It was not possible to incorporate a diagnostic instrument such as the Structured Interview for DSM-IV Dissociated Disorders (SCID D) into

this study. The whole aim of the audit was to raise awareness and interest among the Psychiatric Professionals and identify links between undetected dissociation (both dissociative symptoms and dissociative disorders) and repeated hospital admissions. It was hoped this would be a first step towards formulating a more appropriate treatment model at outpatient level. The results of the audit revealed a significant percentage of patients with dissociative symptoms and with clear indications that some are likely to suffer from a Dissociative Disorder. Some correlation was demonstrated between the presence of dissociation and repeated hospital stays. This has helped staff to have a better understanding of slow responders or non-responders to standard biological treatment regimes (DiUK 2002).

It seems to me that any research, which raises the awareness of the possibility of dissociation for the medical and psychiatric professionals, can only be beneficial. This and other quantitative studies help add credence and weight to the questioned existence of the phenomena and gives hope to the many sufferers.

There is continued exciting research going on. Linda Meyer-Williams (1994) of the University of New Hampshire has conducted some research on amnesia and delayed recall for experiences of childhood sexual abuse. She did two studies as part of a research project involving detailed interviews with 129 women who, 17 years before, had been evaluated in a hospital emergency room after being sexually abused. In Study 1, Williams found that for the documented incidents of sexual abuse that had occurred 17 years earlier, 1 in 3 women did not report those abuse experiences. 68% of those who did not report the documented incident of sexual abuse reported other sexual assaults experienced in childhood. Williams also found that the younger the

child at the time and the closer the relationship with the abuser, the greater likelihood an incident was (apparently) not remembered. In Study 2 Williams reports evidence that some adults, who claim to have recovered memories of sexual abuse, recall actual events that occurred in childhood. 129 women with documented evidence of childhood sexual abuse were interviewed and asked about their abuse history. 1 in 10 women (16% of those who recalled the abuse) reported at some time in the past they had forgotten their abuse. Those with a prior period of forgetting – the women with 'recovered memories' – were younger at the time of the abuse and were less likely to have received support from their mothers than the women who reported that they had always remembered their victimisation. The women who had recovered memories and those who had always remembered had the same number of discrepancies when their accounts of abuse were compared to the reports from the early 1970s.

These findings are important because they are based on a prospective study of all reported cases of child sexual abuse in a community sample. Because the abuse was documented in hospital records this is the first study to provide evidence that some adults who claim to have recovered memories of the childhood sexual abuse recall actual events, which occurred in childhood. These findings are also not limited to a clinical sample of women in treatment for sexual abuse. The findings document the occurrence of recovered memories. There is no evidence from this study that therapy or therapists fostered the recovery of memories. For this sample memories resurfaced in conjunction with registering events or reminders and an internal process of rumination and clarification. For women with greater economic means than those who comprised this sample, therapy may play a greater role in recovering memories of childhood sexual abuse (Hopper 2002).

Although William's research did not look directly at the possibility of loss of memory recall being due to dissociation itself, it does lend more credence to the existence of recovered memories and DID in some clients thus disputing the claims of those opposed to the idea of recovered memories as a truth. It paves the way for looking for scientific evidence of DID as a possible reason for that memory loss, that memory recovery, following trauma which occurred many years in the past, is more than a possibility and that DID is to be explored as a viable condition.

Dr Frank Putnam (1989) of the National Institute of Health believes that the stress of prolonged and systematic trauma during early childhood can cause the brain cells to become flooded by excessive neurotransmitters and neuromodulators and that chronic abuse actually changed the brain's physiology. Laboratory studies have shown that high levels of cortisone, dopamine, adrenaline and noradrenaline flood the brain following times of extreme stress and remain there for months affecting emotional and brain cell function. Cortisone remains high for many months, affecting emotional and brain cell function. It is thought that this may be the source of the development of brains, as in DID which are capable of processes unavailable to those who are not dissociative (Burdess 2000). This would comply with Kluft's Factor 1.

In 2004 Nijenhuis et al in an article in the Australian and New Zealand Journal of Psychiatry discussed '*Trauma-related Dissociation: Conceptual Clarity Lost and Found'*. Current conceptualizations of dissociation were critically examined and were compared with a new theory that incorporates classical views on dissociation with other contemporary theories related to traumatization. It viewed dissociation as "a

lack of integration among psychobiological systems that constitute personality, that is, as a structural dissociation of personality" (p906). It showed that many current views of dissociation are "overinclusive and underinclusive" (p906).

"They embrace non-dissociative phenomena – rigid alterations in the level and field of consciousness – prevalent in non-traumatized populations, and which do not require structural dissociation. These views also largely disregard somatoform and positive symptoms of dissociation and underestimate integrative deficiencies, while emphasizing the psychological defensive function of dissociation. They do not offer a common psychobiological pathway for the spectrum of trauma-related disorders." Nijenhuis et al concluded that

"Limitation of the concept of dissociation to structural dividedness of the personality sets it apart from related but non-dissociative phenomena and provides a taxonomy of dissociative symptoms. It postulates a common psychobiological pathway for all trauma-related disorders. Trauma-related dissociation is maintained by integrative deficits and phobic avoidance. This conceptualization advances diagnosis, classification, treatment and research of trauma-related disorders" (p906).

2.5. CONCLUSION.

There seems to be no doubt that DID is a recognised condition. Both the trauma based model and the socio-cognitive model agree that DID clients present with dissociative symptoms that go beyond the acceptance of normal. However the dispute lies in how the client reaches this state and how they are treated, and each camp remains mutually exclusive.

DID continues to remain hotly debated and hotly disputed. It seems to me that until legitimate use of the term DID is confirmed with convincing psychobiological changes as evidence of its existence as a discrete condition this will continue, with each camp fighting for credibility over the other. In my opinion this is not helpful. At the very least at this stage the aetiology of DID needs to allow for a mix of different influences that varies from case to case. My experience puts me very much in the trauma-based camp. I very much see DID as an adaptive response to severe trauma

and not a psychotic response but that does not mean that I cannot see how a socio-cognitive situation could arise. The debate makes me feel very much on trial both for my credibility and my sanity. If I was on trial in law I would at least be considered 'innocent until proven guilty'.

It excites me to know that there is continued scientific research going on. I am of the view that it will eventually prove that DID is an extraordinary defence mechanism originating in the psyche but in order for therapists to work with such clients it seems to me that there needs to be a balance in this research. There should be some emphasis placed on the clients' emotional experiences, from their own perspective and not just from the observations of clinicians. It was, I suppose, with this in mind that I began my own study using a phenomenological method to explore my experience. I believe that those with DID could be given a 'voice' through this form of rigorous research process, with the ultimate aim of informing clinical practice and enhancing understanding of the 'lived world' of people with DID.

CHAPTER 3.

METHODOLOGY.

"Having made a discovery, I shall never see the world again as before. My eyes have become different: I have made myself into a person seeing and thinking differently. I have crossed a gap, the heuristic gap, which lies between problem and discovery."
(Polanyi 1962. p143)

3.1. INTRODUCTION.

> "Research can be seen as a complex form of collective learning. It is through research of one kind or another that the community of members of any discipline develop their shared capacity to act in response to problems. It is important to recognise that any piece of research exists in relation to other investigative studies. No matter how original a new research question or technique might appear to be, it can only be asked or constructed on the back of all the questions or techniques that have gone before it. One of the essential tasks in any research project is, consequently, to become familiar with other relevant work in the particular area of interest. In other words it is necessary, at some point, to read and review the literature, to map a context within which the study can be located."
> (McLeod 1997. p11)

The intention of this chapter is to outline and discuss the methodology used to gather the information and data for this research, which I hope, enables me to give justice to the research question.

3.2. CHOICE OF METHODOLOGY: Qualitative v Quantitative.

Traditionally, it seems to me, research in counselling deals with numbers of people and their central tendencies (means and medians) and their variations (deviations and ranges). Many studies publish average or typical findings. My own position is that the equally rigorous, more informal methods of research have much to offer the counselling field. Quantitative research used in our field has value according to the

specific purpose and goal of the research but it can in some cases over emphasise precision and quantification at the expense of exploring complexity. The problems we encounter in counselling, I feel, are often better served by research methods that study people in their real, contemporary worlds, in their entirety and with methods much more qualitative in nature. For this reason I have opted for a qualitative approach to this study.

3.2.1 Why quantitative is not always suitable.

The French physicist, August Comte used the term 'positivism' as synonymous with science. It is now taken to mean objective inquiry based on measurable variables and provable propositions. Positivist research emphasises that science needs to be concerned with the explanation and prediction of observable situations (Kincheloe and McLaren 1991) and is based on rationalistic, empiricist philosophy. Because quantitative data typically involves numbers, there are some researchers who feel that it is better (or more scientific) than qualitative data. Quantitative research is deductive, whereas qualitative research is inductive. In qualitative research, a hypothesis is not needed to begin research. However, all quantitative research requires a hypothesis before research can begin. Being rooted in the positivist paradigm quantitative research requires the researcher to record either directly or through a coding system in order to deduce inferences based on these observations.

When choosing between a quantitative or a qualitative approach the role of the researcher needed to be considered. Quantitative research ideally requires the researcher to be an objective observer who neither participates in nor influences the subject of study. As I am both the researcher and the researchee in this study this did

not fit. On the other hand in qualitative research it is thought that the researcher can learn much from participating in and /or by immersion in the research situation. I live with DID on a daily basis. Immersion is ensured! Being both the researcher and the subject being researched also qualifies me more than adequately as actually participating in the research and hence eminently lending this study to a qualitative methodology. It also raises questions which I will address.

Quantitative research is an efficient method of deducing and perhaps answering questions around aetiology, frequency, gender, prevalence and expected outcomes however it cannot deal with small numbers or single data or with the complexities of the human mind.

It was important for me to find a methodology that suits both the reason for and the choice of subject for research – and my temperament. Besides, an extensive review of the literature and many hours of taped counselling sessions and the hundreds of pages of transcript that this generated did not seem to lend them to quantitative research. We have benefited much in our time from science but it seems to me that the positivist approach to investigation is only appropriate in answer to certain types of questions. This method involves much analysing of data, breaking down a whole and doing a thorough investigation of it and at the root of this method, in the popular imagination, is an impeccable logic. It seems to me that we think that if something is logical then it is true, so our language and therefore our speech is an expression of that logic. Very little about DID seems logical but that does not mean it does not exist or is not true.

Some time ago I read a book which introduced me to Shin'ichi Hisamatsu, a contemporary Zen Buddhist and what he had to say resonated with what I was looking for and subsequently what I discovered listening to the taped counselling sessions.

In Zen, it appears there is a saying 'Not relying on words or letters'. It is not supposed to deny language or words or intellect but rather it points towards the root of speech – what is "prior" to speech. It is not expressing 'prior' in terms of time, more in an ontological sense. Hisamatsu (1965 p23) seems to be suggesting that "not relying on words or letters" is to be "taken to mean 'prior to words' in the sense of not depending on words, not being bound or caught by words" – the words pointing to something beyond themselves.

When a word is spoken something is said, but not everything is said. Words also have a power to them. They can reveal yet then can also conceal. When revealing they can be healing. There is great power in the right word spoken in the right place at the right time and to the right person.

Sometimes words conceal more than they reveal. Sometimes there are just no words to express what is being thought or felt or experienced. No words give justice to the moment. How then can this be measured? My sense is that it can't. It is here then that we need to look for a way to enter into these moments with understanding but perhaps with no expectations or explanations. Listening to the tapes I am aware that more than words can be heard. Much can be obtained from the silences and innuendos and the nuances in felt sense, which cannot be acquired by quantification. They (the tapes) require more than the 'breaking down of the whole' in order for information to be

gathered, they seem to require a 'living' understanding – a being with them. It seemed to me that a heuristic approach would provide the best way to achieve this even though words would be needed to present what is discovered.

When dealing with and listening to human experiences, I think we go beyond the event to a deeper complexity. I am not suggesting that what statisticians offer to social scientists is insignificant, on the contrary, what they provide us with is a set of tools which

> "…permits generalisation of remarkable accuracy and simplification of great help in making strategic, large-scale and population wide decisions."
>
> (McGuiness, 2001)

However, as counsellors we have to go beyond the quantitative, we deal with the unique experiences, that which qualifies the quantitative. If we want to investigate the unique, then as McGuiness (2001) says we must either

> "…settle for the generalisations that distance us from the complexity, or devise methods that are more subtle, more sensitive, more atomistic."

We currently live in a society where such words as stress, pressure and drive are a part of our every day vocabulary. At work we are driven by deadlines, performance related strategies and targets. At home we are driven by how the media thinks we should look and behave and what we should own or wear - all based on quantitative research or 'hard-data'. We are therefore influenced by facts and numbers.

In his paper presented to the International Counselling Conference in Durham 2001 *'Quantifying Pain: falling into the measurement trap.'* McGuiness put forward a

strong and moving case for looking beyond the hard data. In recounting the horrific and emotionally painful experiences of a Kenyan refugee he asked the apposite questions

> "How do we research that? What scientific method will help us investigate this complex agony?"

This research has not been undertaken to prove or disprove a hypothesis or a theory. I am looking for truth not necessarily certainty. I want to attempt, to get away from the thin-data (Geertz 1973) and look behind one of the statistics, namely my experience; to bring a statistic alive and make it real in the hope that all the others making up the remaining numbers can believe they are worthy of being heard and matter. I hope also that the findings will contribute to the knowledge base that therapists and clinicians have when working with the DID client and those who have experienced severe trauma. I hope to encourage that we be influenced by fact and experience.

In partly justifying my qualitative based research I make no apologies for the following large quote, again from McGuiness who can express my reasoning better than I can.

> "What implications, then, does the phenomenon of 'measurement-madness' have for counsellors in the UK at the beginning of the 21st century as practitioners and researchers? One consequence is a real danger that we are pushed into authenticating our practice and our research in inappropriate ways. There is a vast and growing literature in which researchers share insights into ways of accessing and giving meaning to fragile, subtle, ephemeral realities of human interaction, yet such is the political domination on research bodies, university committees, among journal referees of those who espouse (and have expertise in) only positivist-empiricist approaches to reality, that a major battle needs to be fought to establish the limitations of traditional research methodologies, and the potential of the new paradigms.
> John Rowan and his colleague John Reason, (1981) writing compellingly about the brittleness of so called 'hard-data', its insensitivity to, and incapacity to deal with

the complexity of individual human behaviour put it thus:
"In order to get away from the subjectivity and error of naïve enquiry, the whole apparatus of experimental method, quasi-experimental method, statistical significance, dependent and independent variables is set up. While it does encounter some of the problems of naïve enquiry, it also kills off everything that it comes in contact with, so what we are left with, is dead knowledge. (Rowan and Reason. Human Inquiry p.xiii, 1981)'

He goes on to say

> "They appear to present a case that argues that the demand and quest for "rigour" drives the compliant social scientist to offer it….as the kind of rigour that characterises 'rigor mortis', an analysis of human reality, a version of 'truth' that offers the neatness of number, but also its incompleteness; the cleanness of figures but generalised and simplified in a vain attempt to contain the messiness of human reality."

As counsellors it is the "messiness of human reality" that we deal with. We don't just deal in numbers; we work face to face with the problem, one-to-one. When you are alone with your client listening to their story, somehow numbers can seem irrelevant. It is what lies behind the statistic that is more helpful, an insight into what makes the statistic tick, in order for us to walk alongside our clients in their anguish as they try to find a meaning.

3.3. QUALITATIVE RESEARCH

How best can we describe qualitative methodology? The simplest though somewhat circular definition is to say it involves methods of data collection and analysis that are non-quantitative (Loftland & Loftland 1984). Another way of defining it is to say that it focuses on "quality", a term referring to the essence or ambiance of something (Berg 1998: Adler & Adler 1987) I was ultimately persuaded to use a qualitative methodology by seeing Sanders and Liptrot's (1994) list of fundamental differences

between quantitative and qualitative research methodologies, realising how clearly that my research focus lay in qualitative research.

Quantitative requisites	Qualitative requisites
structure	structurelessness or chaos
outcome	process
objective	subjective
external frame of reference	internal frame of reference
neutral and detached	involved
'science'-centred	'person'-centred
analysis	synthesis
taking apart	putting together
variables are identified and measured	complex variables that interact and are difficult to measure
numbers	thoughts, feelings, words and patterns
reduction to simple units	welcomes complexity and pluralism
peoples as objects	people as persons
measurable and observable	experiential
abstraction of facts	description of experiences
deduction from fact	intuition
technology	nature
quantity	quality

Table 1. Sanders & Liptrot (1994)

There are many methods of qualitative research. The task was to find the most suitable for exploring the question I had formulated.

1) What, if any, are some of the overriding feelings that are generated as a result of DID in therapy?

There were secondary questions which also arose.

1) How will the outcome of this research be of value to therapists and clients?

2) How would I feel about this research being placed in a public arena?

3.3.1 Study of an Individual Rather Than a Group.

In exploring the various methods I became more aware that my research could be identified as fitting into several categories. The first seemed glaringly obvious. It was a single in depth case study. It was chosen as a single study for two reasons

a) I was looking to get behind statistics to understand the complexity of emotions felt by someone experiencing DID

b) The ethical minefield of using someone who is currently in therapy with DID was too enormous to consider because of the vulnerability of such clients and because of the difficulties and practicalities of gaining consent from the various 'alters'. Vulnerable clients can often give consent to research participation because they either wish to "please" their therapist or to "repay" them in some way. Use of me as the subject of research overcame much of this.

Hence when considering a research strategy, using a survey or a history did not seem appropriate.

Research in counselling is so much more alive and useful when it deals with current problems and situations. So much of research has sought to establish basic laws of human functioning for all time. In an article in the American Psychologist, Cronbach (1975) challenged this, saying; it is enough to understand how people function during any one period. In searching for research topics we need therefore to look to those who are in the vanguard of professional functioning or experience and are trying out new methods and ideas. It is generally accepted that DID is a response to severe and

enduring childhood trauma usually abusive (sexually, physically or emotionally) in nature. In recent years children globally have been subjected to horrors beyond our imagining through war - we only have to listen to the victims of the Chechnyan and Bosnian wars and the African inter tribal conflicts – and even more recently the Internet paedophile exposure and the Asian tsunami earlier this year. It is my belief that we will see a rise in the incidence of dissociation and DID as a result of these atrocities. It will therefore be essential for therapists to have some understanding of how these people might feel. With the increase of asylum seekers in Britain, many of whom have been the victims of these conflicts, we need to be sensitively aware of the phenomenon of dissociation and other reactions to trauma.

So rather than study several DID subjects I decided to look in depth into one. I felt this would lend itself far more to looking into the complexity of DID and give me the opportunity to deepen my understanding of it. I think that in studying several subjects I would be drawn to the academic/political pressure to provide average or typical findings. I want to look at the uniqueness. In doing so I hope it will encourage others to look at individual uniqueness and redress the balance of statistics and averages. It is a study of one single case done by the client who is also a therapist.

McLeod (1994) advocates client experience studies as "an important strand of process research". There have been studies by therapists and external observers into how clients perceive both the processes and the outcomes of therapy (Kaschak 1987). The idea is that in knowing more how clients feel about and perceive themselves and the counselling process, the therapist will become more sensitive and effective and

engage more meaningfully in the therapeutic relationship. The main aim of client experience studies he says is

> "…to create a picture of what the therapy is like from the point of view of the client. It is therefore important to distinguish between client experience studies and other types of research (e.g. many outcome studies) in which clients are asked to answer questionnaires on the basis of their experience, but where the goal of the study is to assimilate that experience into a measure of, for example, empathy or satisfaction, rather than describe the experience as such." (p156)

There have been client experience studies using questionnaires (Strupp, Wallach and Wogan. 1964: Orlinsky and Howard 1975, 1986: Stiles 1980: Stiles and Snow, 1984) and using in depth semi structured interviews (Brannen and Collard 1982: Howe 1989: Timms and Blampied 1985) in order to explore the experiences of clients. In 1990 Rennie applied the grounded theory approach to research into a counselling session with a client where the client was subsequently asked in depth what s/he had experienced in that session. The session was recorded and subjected to rigorous interpersonal recall (IPR) to discover the client's felt sense of the counselling experience (McLeod 1994).

These studies, although done to understand client experience, were all carried out by therapists and therefore there will inevitably be some researcher interpretation of what the client is communicating. They were not conducted by the clients themselves. They were also done to understand client's perceptions of counselling and the process, not to look at a particular phenomenon that a client is bringing.

This study does not involve questionnaires or structured interviews (semi or otherwise) and is not carried out by the therapist, neither is it being carried out to

particularly look at the therapeutic process although inevitably this cannot be totally ignored. It is carried out to explore a phenomenon from what I think is an uncharted angle. It is a study carried out by a client into her own counselling sessions over a long period of time in order to look in depth into a difficult and often misunderstood phenomenon and the effects it has on her 'being'. The outcome, I hope, will be of value to both therapists and clients alike enlightening them on how DID sufferers may expect to feel.

3.3.2. Case Study.

This is a way of investigating or exploring the world by following, describing and analysing a particular instance or case.

> "In general, case studies are the preferred strategy when "how" or "why" questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context."
>
> (Yin 1984 p1)

This research fulfils all these criteria. A "how" question is being asked, "How can the emotions felt by someone living with DID affect his/her behaviour?" Even though I as the researcher am one of the participants I do not have control over how the counselling sessions will go and the focus is on DID within my real life situation.

Yin (1981a, 1981b) explains that a case study is an empirical inquiry that

> "…investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used."

As with most forms of methodology there are different types within each discipline. Within the discipline of the case study Yin (1984) suggests there are 'exploratory'. 'explanatory' and 'descriptive' studies. He posits a common misconception that these various research strategies should be arrayed hierarchically – that case studies are only appropriate for the exploratory phase of an investigation that surveys and histories are appropriate for the descriptive phase and that experiments were the only way of conducting explanatory or causal inquiries. For Yin this hierarchical view is incorrect. He offers the view that experiments with an exploratory motive have always existed and that the development of causal explanations has been a serious concern of historians.

3.3.2.a. Descriptive Study.

For the case for descriptive studies Yin (1984) cites the example of William F. Whyte Street Corner Society (1943) as being recommended reading for decades in community sociology. In his study Whyte (1993 4thed) traces the sequence of interpersonal events over time, describes a subculture that had rarely been the topic of previous study and discovers key phenomena. The study's value is, paradoxically, its generalizability to issues on individual performance, group structure and the social structure of neighbourhoods. It seemed to me that my research slotted into this comfortably. It traces a sequence of events - counselling sessions over a period of time; describes a subculture having rarely been the topic of previous study – I have found no evidence of a client with DID currently in therapy researching into their experienced emotions; and discovers key phenomena.

3.3.2.b Explanatory Study.

In describing how a single case study can be used to pursue an explanatory purpose Yin (1984) cites Graham Allison's study of the Cuban Missile Crisis in 1971. Allison's objective was to pose competing explanations for the same set of events and to indicate how such events may apply to other situations. (e.g. the United States involvement in Vietnam and nuclear confrontation in general.) This is not my objective.

3.3.2.c Exploratory Study.

According to Yin (1984) an exploratory study begins with two criteria, "rationale and direction" even if initial assumptions are later proved wrong. Firstly, there needs to be some reason for doing this research – I could find no evidence of previous in depth studies around the emotional life of a DID sufferer and as a sufferer it would be immensely helpful to understand what emotions could be around and how they have and do affect my life. This could then hopefully be explored or applied to or compared with other DID sufferers. Secondly, in the desire to get behind statistics, doing an in depth study of an individual seemed to be the way to explore the complexities.

3.3.2.d Pluralism in my Case Study

Considering the case study strategies it seems to me that for what I am hoping to achieve a more pluralistic approach to case study was needed. It feels that there is some overlap among the strategies particularly between the descriptive and the exploratory disciplines. The need to explore the phenomena for research (What are

some of the overriding emotions generated in a client with DID in therapy?) will rely heavily on the descriptive nature of the content of the research data (How do they affect behaviour?).

3.3.2.e Advantages of Case Study.

A case study can contribute uniquely to our knowledge of individual, organisational and to social and political phenomena (Yin 1984) and is a common research strategy among psychologists, sociologists and social scientists. Case studies arise out of the desire to understand complex social phenomenon which is the precise nature of this study. Case studies allow the investigation to retain the holistic and meaningful characteristics of real-life events (Yin 1984).

The case report is ideal for providing the "thick description" thought to be essential for enabling transferability judgements. The case study is at its best a "portrayal" of a situation (Guba and Lincoln 1985)

> "It may read like a novel but it does so for the same reasons that novels read like novels – in order to make clear the complexities of the context and the ways these interact to form whatever it is that the case report portrays." (p214)

A case study provides an "ideal vehicle for communicating with the consumer". It provides him/her with a "vicarious experience of the inquiry setting" (Guba & Lincoln 1985) According to Guba and Lincoln (1985) a case study should provide the reader with an experience of feeling the content and its situation.

> " The aim of the case report is to so orient readers that if they could be magically transported to the inquiry site, they would experience a feeling of déjà vu – of having been there before and of being thoroughly familiar with all its details…..the

> case report provides the reader a means for bringing his or her own tacit knowledge to bear; if the description is sufficiently "thick" then reading it is very similar to being there and being able to sense elements too nebulous to be stated propositionally." (Guba & Lincoln 1985 p214-215)

3.3.2.f Prejudices of a Case Study.

For some reason single case studies have been viewed as less desirable than other research strategies. One of the criticisms is that there can be lack of rigor in a case study allowing for biases to influence the direction of the findings.

> "…investigators who do case studies are often regarded as having deviated from their academic disciplines, and their investigations as having insufficient precision (that is, quantification), objectivity and rigor." (Yin 1984)

It is therefore important to work hard to avoid this situation. However I would suggest that biases may also affect other forms of research perhaps, for example, where questionnaires are used. Questions can depend on the authority of the questioner and the answers could be based on what the person answering them feels the questioner wants to hear. Gottschalk (1968) suggests biases can influence the conducting of historical research.

Another criticism of case studies is that they provide little basis for scientific generalisation (Guba & Lincoln, 1981). Yin (1984) suggests that we can say the same for single experiment. He says that scientific facts are rarely based on single experiments but that they are usually based on a multiple set of experiments, which have "replicated the same phenomenon under different conditions". He suggests the short answer is that

> "…case studies, like experiments, are generalisable to theoretical propositions and not to populations or universes." (p21)

So case studies like experiments do not represent a sample but the goal is to expand and generalise theories not to enumerate frequencies, which for me is the whole purpose of this study along with enhancing public interest. All research has to start somewhere. The aim is that researching with one case study will engender an interest and encourage further research in the same style and area. If several people engage in the same form of study then eventually hypotheses and theories can be made.

One other criticism of case study research is that it can take too long and produce massive amounts of material. This is a very valid criticism which I feel could be overcome with some forward planning and discipline. It is a criticism which perhaps is incorrectly confused with a specific method of data collection such as ethnography or participant-observation which usually requires long periods of time in the "field" and emphasise detailed observational evidence.

3.3.3. Ethnographic Research.

Ethnography is the process of describing a culture or a way of life from a peoples' point of view. It is also described as 'field work'. Ethnography sees each person as a reflection of their culture in that their gestures, nuances, symbols, sayings, pictures, songs and other things have some implicit meaning for others in the same culture.

It involves observation and note taking; Geertz (1973) called it "thick description". The notes should contain rich, detailed descriptions of everything that went on and there should be no attempt at summarising or hypothesising. The notes should capture

as factual description of the study as possible in order to allow multiple interpretations and then later to infer cultural meaning (Neuman & Wiegand 2000). A coding procedure could be used for this.

One of the assumptions of the ethnographic method is naturalism or leaving natural phenomena alone. In practice the researcher tries to be invisible, watching and observing what is going on. At some point the researcher goes away, retreats to a quiet place and makes notes.

Whilst it can be said that I do, to some extent, observe the process and what is going on through listening to the tapes after each session and that I have made notes, I am by no means an invisible observer. I am very much the participant in the process. However I am aware that some of my approach to design has a somewhat ethnographic orientation.

3.3.4 Narrative Research.

Narrative inquiry is the process of gathering information for the purpose of research through story telling. The researcher then writes a narrative of the experience. According to Connelly and Clandinin (1990)

> "Humans are storytelling organisms who, individually and collectively, lead storied lives. Thus, the study of narrative is the study of the ways humans experience the world."

The narrative researcher makes use of interviews, journals, letters, oral stories, autobiographies and pictures as methods of narrative inquiry. S/he would then construct their own narrative of the study using perhaps scenes and plots. The

outcome is a mutually constructed story out of the lives of the researcher and the participant (Connelly & Clandinin. 1990).

Ruth Behar (1996) offers a line in her book 'The Vulnerable Observer' which I think summarises the approach taken in a narrative study researching the impact of secondary traumatic stress among counsellors working with trauma.

> "If you don't mind going places without a map, follow me." (p33)

Much of my data collected tells a story through the sensitivity of counselling sessions. A picture is painted by the added use of notes and reflected thoughts and quotes from literature which seem apposite to the subject under discussion. Even the odd illustration has been used where I have felt it adds to the overall sense to be portrayed to the reader.

The transcripts provide the words from which the meaning is found. Language is our most used form of communication and one which 'I' prefer, although one of my alters, Emily, finds difficulty with words and uses another form of communication when engaging with K, - the use of buttons to describe a memory or to give him information. Because language is often thought to be transparent, it is wrongly assumed that the structure of the transcript should portray the intended meaning. However I do not believe it is possible to reproduce exactly people's speech or to completely express the intention of silences and nuances. My experience here supports the view of Flick (2002) that the importance and the focus is on "…attaining the maximum exactness in classifying and presenting statements and breaks etc." As

researchers all we can do is attempt to reproduce the communicative events as closely as possible and even though they will never be exact, I feel in this case I have an added advantage being both the researcher and the researchee.

Clients in therapy often need to 'tell their story' before going back to explore meaning or behaviour. The taped sessions of this study from which the data has been collected is full of story around which much therapeutic work is done with the aim of making change to perceptions and behaviours. Whilst as researcher I have not taken this data and produced a narrative from it in terms of scenes and plot, the data collected relies heavily on the stories being told by 'me' and the alters.

Narrative inquiries do not lend themselves to replicability and are not generalizable but as counsellors we do not deal with the generalizable, rather the unique. If what we can observe and learn from one unique individual will give us an insight to what we may find in another of similar circumstances then it can only serve a positive service and in that sense may become generalizable.

3.3.5 Phenomenology.

I chose a phenomenological approach to this qualitative inquiry. This approach seeks to explain the "structure and essence of the experiences" (Banning 1995). The aim of phenomenology is to produce an "exhaustive description of the phenomena of everyday experience, thus arriving at an understanding of the essential structures of the 'thing itself' (McLeod. 2001).

Husserl (1913 trans 1931) uses the phrase 'natural attitude' to describe assumptions that we normally employ to make sense of our everyday world. Phenomenology takes us beyond that taking what McLeod (2001) says is a "transcendental attitude" which he says is a "bracketing-off of such assumptions". This can be demanding of the inquirer. It requires a kind of withdrawal from the world, and a willingness to lay aside existing theories and beliefs. It is about going on a journey to different places and finally returning to the start and seeing it from a different perspective or in a different light.

My research produced an exhaustive description of the phenomena of DID. It was a long and arduous journey that took me through this material finally bringing me to an understanding of much of the essence of the research. I have not as yet returned to the beginning of the journey as it is still in progress. This research is done during ongoing therapy.

The difficulty lay in that phenomenology involves using language to describe what lies beyond language and in doing so can invite criticism that it is perhaps attempting the impossible. In other words what can be known is only what can be said. There are obvious issues here concerning human nature and the role of language and culture in our lives. (McLeod 2001). Emily uses little language to convey her meanings, choosing the medium of button work with K. He seems to have little difficulty understanding her meanings, however I concede to language to report to the reader.

3.3.6 Heurism

Using my own experience as data led me to follow a reflexive form of phenomenology in heurism. The term heuristics comes from the Greek word *heuriskein* meaning to find out or discover. Moustakas (1990) considers heurism to be a "discovery process", as distinguished from "verification and corroboration (p207)". It is a way of self-enquiry undertaken in dialogue with another in the hope of discovering the underlying meaning of, in this case, feelings associated with a dissociative existence. A heuristic approach allowed me to

> "…know the essence of some aspect of [my] life through the internal pathways of the self". (Douglas and Moustakas 1985, p39).

Heurism is no easy form of research. There is an impelling need for commitment and dedication. Heuristics can be used in any discipline, in any research endeavour where the inquiry is breaking new ground.

> "When there is no idea of where the researcher or the territory is going (i.e. there is no paradigm established for the field), then exploratory discovery, rather than testing hypotheses, is the goal." (Sela-Smith 2002)

It requires much of the researcher, a passionate need to know about the research question or themes and an ability to allow the research to take one over fully. Living with DID ensures immersion in the topic! I have also learned that there is a need for patience and trust especially during the incubation period when waiting for illumination. This was particularly difficult as I easily question trust and my ability,

and often find it difficult to discern when I have the right to challenge. Learning to be critical was quite a hurdle to jump. The word 'criticism' has very negative connotations and something that was always levied against me so to learn to challenge and constructively criticise experts and the professionals took and still takes, some courage.

There is also the challenge of synthesis and the final outcome can resemble what has come to be called by Denzin and Lincoln as "bricolage"

> "…a complex, dense reflexive, collage like creation that represents the researcher's images, understandings and interpretations of the world or phenomena under analysis." (Denzin and Lincoln 1994 p2-3)

I think it would be fair to describe this research as resembling a "bricolage".

Also according to Moustakas, it appears that an important application of heuristic research has been its contribution as a process of discovery in studies of what has come to be known as symbolic growth experience (SGE) i.e. a dramatic, often sudden move in beliefs, perceptions and understandings or conceptions. This alteration in perspectives usually comes about as a result of some external happening and this in turn

> "…launches in some measure a new attitude, a new process of learning, a character or personality shift in identity and selfhood." (Moustakas, 1990 p99)

This description was so close to my own experience of person-centred counselling, both as a client and as a therapist that I connected immediately with this approach. I

could connect too with Willard Frick (1990), a pioneer of the symbolic growth experience when he expounded that

> "…two characteristics that represented permeating themes of the symbolic growth experience (1) Integration, order and stability through which the individual attains self-consistency and brings unity and completion to an incomplete structure of personality: and (2) differentiation, change and growth through which the individual discovers and actualises new facts."
>
> (Moustakas1990 p100)

In his observations of his studies of SGE and heuristic research Frick discovered a freedom of exploration and investigation and an assumption of the integrity given to the researcher which released him from the constraints that other, perhaps more conventional research approaches applied. The result seemed to be the possibility of richer understanding and awareness in the development of identity, personality and therefore of self.

Heuristics feels congruent with counselling and therefore more readily accessible to me with a counselling background. There are other approaches that feel equally congruent such as human enquiry whose key exponent is Peter Reason (1986).

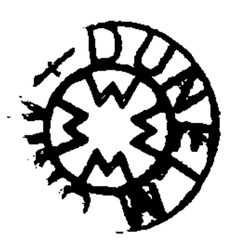
> "What heuristics and human enquiry share in common, and what clearly puts them in the qualitative camp, is that they both make use of the researcher's involvement with the research, both as a source of data and in the process of data analysis. Reason (1994) argues for what he calls 'critical subjectivity', by which he means an acceptance of our involvement with those we research, but an involvement that is 'critical, self-aware, discriminating and informed' (Reason 1994. p11)..counsellors working within the psychodynamic and person-centred traditions are familiar with the use of self in their work. Person-centred counsellors use empathy and congruence to guide their work while psychodynamic counsellors put trust in working with their counter-transference….So counsellors are used to monitoring the way their clients affect them and using these data to inform their work. Increasingly this process is seen to be an holistic one involving body, mind, emotions and spirit.
>
> (West 1997 p1-2)

But for me it was the pull of heuristic research. As Moustakas says

> "The power of heuristic inquiry lies in its potential for disclosing truth. Through exhaustive self-search, dialogues with others, and creative depictions of experience, a comprehensive knowledge is generated."
>
> (Douglass and Moustakas 1985 p40)

One of the things that I have said many times over the years throughout my relationship with K is that 'I' need to know the truth of what happened and to discover the truth about who 'I' am and 'my' history. Right from the very beginning 'I' have wanted to know. It has almost been an obsession for the quest of the truth even if it meant learning truths that were painful or difficult to acknowledge. One of the things about dissociation is that it is a method of concealing truths in order to prevent pain, and for survival. Learning the truth and then being able to accept it is the pathway leading to integration and a measure of wholeness. Accepting truths and learning to live with them can be a God-awful process. Heurism was a way, as I saw it, to learn the truths and to allot justifiable guilt and dispel what was inappropriate. It was a way of looking truth in the face. The challenge was for 'me' to look at them and experience them.

Moustakas' (1990a) model states that there are six stages or phases to heuristic research: initial engagement, immersion, incubation, illumination, explication and creative synthesis and although heuristic research moves through these phases it is not necessarily in that order and is not a rigid framework.



3.3.6 a. Initial Engagement.

According to Moustakas (1990a),

> "Within each researcher exists a topic, theme, problem or question that represents a critical interest and area of research. The task of the initial engagement is to discover an intense interest, a passionate concern that calls out to the researcher, one that holds important social meanings and personal, compelling implications"
>
> (p27)

My own initial engagement began in 2000. It was not so much the topic but the invitation to self-dialogue that posed the challenge and the encountering of self, or in my case, selves - my autobiography. This inner dialogue needs to be backed up by a passionate need to know because without passion there cannot be sufficient energy for the commitment to complete the research. Well, there was no doubt about my passion for knowledge around DID but what did I concentrate on? What was lacking in the area of DID for me? It seemed to me that there was little written about what feelings/emotions, if any, that were around for someone with DID. How did it affect them in this respect? There was a period of looking inwards for a tacit awareness and knowledge, call it intuition or gut instinct but I began to sense a difficulty or little freedom to express feelings. My questions began to appear. What are some of the overriding emotions felt by someone experiencing DID? How can they affect their behaviour or perceptions? These led to the title of this thesis - A Prison Called Me. A client's perspective of some of the emotional effects of living with DID and how they can affect behaviour.

3.3.6.b. Immersion.

Living with DID ensures immersion! It is there all the time whilst awake and asleep. However I found that the research heightened this even more. I found myself much more open to talking about the subject in both social and professional settings. Suddenly everyone was interested in the phenomenon of dissociation and was not dismissing it out of hand as crazy or implausible or impossible. The more confident I became the less sensitive and vulnerable and defensive I became when questioned or challenged around the subject. I found I was beginning to take risks but still not able to admit publicly that my research was around my own experiences. I have even managed a couple of talks on the subject without revealing my sources.

There were some difficulties with my own internal system. It seemed to disturb some yet excite others. Some of the alter personalities were less than cooperative and occasionally actively destructive. I found that I had to be doubly careful about saving work and backing it up and leaving copies with both **K** and my supervisor to prevent losing it altogether. However, most of the personalities and fortunately those directly involved were happy to engage, even **Leah**.

There were times during the analysis of the data when there was an increase in dissociation because of the heightened feelings that were around. This proved difficult but in hindsight to be expected. After all arousal of feelings is a trigger.

3.3.6.c. Incubation.

This is the phase where Moustakas says

"…the researcher retreats from the intense, concentrated focus of the question….. During this process the researcher is no longer absorbed in the topic in any way or alert to things, situations, events or people that will contribute to an understanding of the phenomenon."

(p28)

It is the time to stand back from the research and get on with other things. This can be a little difficult when it is part of one's living reality. However a spell in hospital came at an appropriate stage of the research and I was given the necessary space for this stage. I was able to allow the question to sit and imbed itself. With this space a certain clarification began to emerge and a new awareness of the phenomenon began to emerge.

3.3.6.d. Illumination.

This occurs when a new awareness and insights emerge and if one is open to tacit and intuitive knowledge. It also may involve

"….corrections of distorted understandings or disclosures or hidden meanings."

(Moustakas1990a.p30)

I have to say this phase was ongoing throughout my research. Having recorded the sessions on audiotape I was given the opportunity to then revisit these sessions and this gave opportunity to question and re question. This was particularly important as much of the sessions were lost to 'me' if alter personalities were out. Being able to hear what they said gave 'me' clearer understandings of them and their experiences and indeed their actual existences and therefore the question at hand. Sometimes

illumination came as a slow dawning and at others it was if things suddenly clicked into place.

3.3.6.e. Explication.

According to Moustakas this is the phase in which we fully examine what has emerged in order to understand its various layers of meaning. He talks of a

> "full elucidation of the descriptive qualities and themes that characterise the experience being investigated."
>
> (p31).

This was for me the personally challenging phase, utilising, focusing, self-searching, self-disclosing – recognising the uniqueness of the experience. It was hard at times to understand 'my' feelings when listening to the alters and their experiences. It was hard too, to sometimes be aware of 'my' beliefs, perceptions, thoughts and judgements prior to 'my' enlightened understanding gained from the sessions and the revisits to them through listening to the tapes. When beliefs about the past and about oneself have been instilled for so long – false beliefs, it is no easy task to remove them, particularly when they are held firmly in place by fear. It takes gentle and patient, persistent erosion. It was an educational phase. Bringing together the discoveries of meanings and organising them into

> "…a comprehensive depiction of the essences of the experience." (p31)

in order to define the major elements was the ultimate challenge.

3.3.6.f. Creative Synthesis.

This is the final phase when all the data is thoroughly familiar. It is the tacit and intuitive process of telling the story using artwork, poetry, prose, nuances, whatever is appropriate. It is a lonely phase, back almost to the state of immersion. It is a time of solitude and concentration on the data and the question or topic so that a creative synthesis emerges.

Moustakas notably emphasises that an academic report is not the only possibility. He says

> "The researcher must move beyond any confined or constricted attention to the data itself and permit an inward life on the question to grow, in such a way that a comprehensive expression of the essences of the phenomenon investigated is realised."
> (p32)

Reason and Heron (1986) put forward a similar viewpoint for human inquiry groups.

Finally to sum up I go back to Moustakas.

> "Behaviour is governed and experience is determined by the unique perceptions, feelings, intuitions, beliefs and judgements housed in the internal frame of reference of a person. Meanings are inherent in a particular world view, an individual life, and the connections between self, other and the world.
> (p32).

Sela-Smith (2002) offers a critique of Moustakas. She acknowledges that Moustakas has "made a significant contribution to research in psychology." However she suggests that

"…due to unacknowledged resistance to experiencing unbearable pain, Moustakas' research focus shifted from the self's experience of the experience to focusing on the idea of the experience" (p53)

This shift she felt

"…resulted in a model of ambivalence, as reflected in the differences between what he introduced as his theory of heuristics and what he presented as its application" (p53)

I was very aware throughout this research that there could be resistance from 'me' when unbearable situations were confronted and pain experienced. My resistance has always been in the form of dissociation and therefore denial. However it is this dissociation and its related emotions that this research is about and I found that whilst 'I' may resist at the time I had to give way to the personalities. Sela-Smith concluded that there were three requisites for heuristic research

- Recognition of the value of a *heuristic self-search inquiry* and a return to the internal perspective
- Acknowledgement of resistance to feeling in the reconnection with the *I-who-feels* (researcher responding to the research and/or findings of the research
- Acceptance of surrender that opens to transformation that can impact the individual, society and all humankind.

My research fulfils all these requirements.

3.3.7. Grounded Theory.

Being very conscious of how this research could be potentially received, it felt necessary to re-ensure academic rigour along with the obvious need for the personal content and disclosures. I did not want it viewed as an exercise in self-pity. The

findings need to be able to stand up in theoretical and professional circles. I decided that a second method of data analysis should be employed in order to make comparisons and contrasts and as a way of triangulating the analysis. Grounded theory analysis is a method of data analysis now fairly widely used by qualitative researchers in the counselling and social sciences fields and arose from the work of two sociologists, Glaser and Strauss in the 1960's. It lends itself to being a more technical approach to data analysis with its labelling and coding components yet there is still the distinctive characteristic that is present in heurism of the analysis work being done alone and through the immersion of a highly motivated individual. Although the emphasis on researcher reflexivity found in heurism is not highlighted in this approach it was obvious I could not retain theoretical sensitivity without being able to reflect on my biases and assumptions. It felt a very compatible approach to heurism and again I felt that my counselling experience was also appropriate to grounded theory, which encourages

> "…theoretical sensitivity…professional knowledge, as well as both research and personal experience, that the researcher brings to his or her enquiry."
> (Strauss and Corbin. 1994 p280)

Although Glaser and Strauss (1967) introduced the grounded theory approach over time it has gradually become more formalised into a series of steps or procedures that the researcher is recommended to take. They can be seen as a set of methodological rules that are

> "…designed to ensure that the interpretation of qualitative material is carried out in a comprehensive and systematic manner."
> (McLeod 2001 p74)

3.3.7.a The Pursuit of Meaning.

This involved going through all the data - the tapes, the transcripts, the diaried thoughts - and breaking them down into semiological units of words, phrases and passages. In turn these were coded and labelled with as many meaning words/phrases as possible. Going through all the data generated several conceptions. This step too is designed to challenge any assumptions and to look deeper into the experience in order to reveal "phenomena and arrive at new theoretical formulations" (Strauss & Corbin 1990:76).

Interpretation is the resting point for making decisions as to how the collected data is integrated into the analysis and what methods should be used. In the process of interpretation different modus operandi can be distinguished. They are commonly called open coding, axial coding and selective coding. They are different ways of handling the data and are often moved in and out of before final results are achieved.

① Open Coding – aims to express data in terms of concepts. E.g. expressions are arranged by their units of meaning so that annotations and concepts can be affixed to them. It can be applied in various degrees of detail and there can be a tendency to be 'bogged' down in this phase. It is important not to lose touch with the aim of coding and Strauss and Corbin (1990) summarise it as such,

> "Open coding in the grounded theory method is the analytic process by which concepts are identified and developed in terms of their properties and dimensions The basic analytic procedures by which this is accomplished are: the asking of questions about the data; and the making of comparisons for similarities and differences between each incident, event and other instances of phenomena. Similar events and incidents are labelled and grouped to form categories." (p74)

This was the difficult part of the coding for me. I can liken it to reading the Bible. Each time I read the transcripts I could make different meanings. It is difficult to use this method to conceptualise the 'felt senses' of listening to the tapes bearing in mind the study is around emotion and feeling.

② Axial Coding – aims to refine and distinguish the categories resulting from open coding. It is in this phase that the categories most relevant to the research question are chosen from the codes and coded notes and subsequently evidence from the text used to validate what has been reached.

> "Axial coding is the process of relating subcategories to a category. It is a complex process of inductive and deductive thinking involving several steps. These are accomplished, as with open coding, by making comparisons and asking questions.
>
> However, in axial coding the use of these procedures is more focused, and geared toward discovering and relating categories in terms of the paradigm model".
>
> (Strauss & Cordin 1990 p114)

③ Selective Coding. – aims to find the main category around which the other categories can be grouped. Here according to Strauss and Corbin (1990) a concept is attached to the central phenomenon of the story and related to the other categories resulting in one central category and one central phenomenon.

This proved to be highly difficult as I was looking for a plural - for more than one thing. I was looking for what emotions/feelings were overriding for someone with DID. The result was several feelings with a link emotion of fear.

3.3.8 Heurism v Grounded Theory.

Although on the surface it looked to me that grounded theory and heurism were compatible approaches I found that for 'me' and my experiences, heurism was a far more apposite method of exploring the 'feelings' associated with DID.

I had expected that I would work with both approaches with the same frame of mind and reference. However the reality was very different. I had not expected that 'my' past experiences would affect the way I responded to each approach. In one sense I had thought that using the grounded theory method would be a 'safe', clinical approach to the quest at hand. Having been used to being disconnected from feeling most of my life I thought I would have no difficulty with grounded theory even though it might prove tedious. I thought I could be objective and work almost dispassionately with the data. Not so. Having been denied the freedom to feel for most of 'my' life, exploring the data through grounded theory felt as though 'I' was on the outside looking in, an observer; where as using the heuristic approach I felt bathed in the experience and very much as if this was 'me' experiencing me. The whole idea of the research was to look at feelings. Grounded theory proved to be a paradox; on the one hand I felt disconnected from the data that I was examining someone else's experiences, yet on the other hand it was generating feelings of anger. When using a heuristic approach to the material I felt very engaged with it and 'attached'. This felt right as I was exploring and analysing my own material. Heurism felt so much more compatible with self researching self. Using grounded theory made me feel artificial and resent the experience. 'I' am after all trying to get in touch with 'my' feelings.

The further I got into working with the grounded theory approach the angrier I was becoming. The coding, categorising and labelling was engendering feelings of their own. Maybe it was something about the terminology. It felt imprisoning in its own way. For me, labelling something seems different to naming it. It seems to me that labelling stereotypes where naming individualises. Labelling felt more compatible with a statistical approach whereas I wanted to get behind a statistic and see the complexity, to let experience run free.

How much of this response to the methods of research I was using was due to the fact that my data was counselling sessions which was gathered three years ago? I am further down the road of my journey now and one of the hopes of therapy for me is that 'I' will change existing to living and that 'I' will be able to feel in 'my' own right. Perhaps therapy is indeed working if 'I' am responding to working in a grounded theory way with some anger. I had thought this would be the safer, more clinical way of the two yet my response to it as a methodology, yielded the most emotion. Had I analysed the data as soon as it was collected, two years ago, then my response to the methods of analysis may well have been different. On-going therapy has put me at a different emotional standpoint now to where I was when the data was collected.

What I did discover was that I felt the heuristic approach lent itself to allowing for 'felt senses' to come through. It was hard to label silences and nuances and also didn't 'feel' right! My conclusion was that for me and for what I was looking to study, heurism was by far the approach that I was most at ease with despite some often painful illuminations.

3.3.9 Summary of Choice of Methodology

a) I decided on a qualitative observational approach to this research because it is more likely to confront the constraints of the everyday social world (Denzin & Lincoln 1994).

b) A phenomenological approach seemed appropriate because of the exhaustive description of DID engendered and the need to go beyond language at times.

c) I chose a single case study in order to get behind the statistics to explore the emotional complexity of the phenomena of DID. As therapists we work face-to-face mainly on a one-to-one basis and deal with the complexity that statistical research supplies. Although a single case study the nature of DID provided material that is more objective than purely autobiographical material which is an added advantage. The many personalities present in a DID client, although facets of them, exist as individuals with their own unique observations, perceptions, memories and beliefs; with the presence of these personalities all making their own input there seems to me to be less chance of assumptions, presumptions or bias. They also provide another source of verification. Although this may seem unconventional in terms of traditional research approach there is a sense in which DID has given me data which is more objective than purely autobiographical reflection.

The choice of strategies in qualitative research left me looking at several possible relevant techniques for looking at and analysing this single-case data. There seemed to be strands of several techniques that could be appropriate, e.g. much of the data was

story telling and ethnographic in that it is describing a culture from one person's point of view.

The choice of a heuristic approach with most of the data together with a grounded theory approach to one tape became the final outcome for analysis. I felt comfortable with the idea of the heuristic approach of immersion, incubation and explication to give rise to a creative synthesis. It also seemed the most logical and applicable method of exploring and researching emotions.

3.3.9.a Advantages of qualitative observational research.

It seems to me that qualitative research expands the range of knowledge and understanding of the world beyond the researchers themselves. In this case too it helps me, and I hope therefore the reader, to see why something is the way it is, rather than just presenting a phenomenon. For instance a quantitative study of DID may find that those who dissociate may display certain emotions and may therefore expect to pass through 'phases' in which they could experience these emotions. However, a qualitative study could reveal why these emotions occur and the effect they have on current behaviour. Being aware that this is a single case study it would be good to make a comparison with another similarly conducted study.

It can allow researchers to identify recurring patterns of behaviour that participants may be unable to recognise and to provide context for behaviours. It can also account for the complexity of behaviour.

3.3.9.b. Disadvantages of qualitative observational research.

There are disadvantages to qualitative research and this needs to be voiced. Researcher bias can bias the design of the study and enter into data collection. The use of audio tapes in this study helps lessen this possibility. Analysis of observations can also be biased and I have tried to off set this by the use of triangulation.

It has also offered an insight into further, follow-up research. I have already found other questions to ask and there are a number of rewarding spin offs. There have been personal gains and the acquisition of new personal skills and understandings that have led to new networks with professionals and academics and the sharing of ideas and findings. This I can see could be a result of most research undertaken.

Any group or individual that is studied is altered to some degree by the very presence of the researcher. Therefore any data collected can be considered somewhat skewed (Heisenberg's principle of uncertainty). Being both the researcher and the researchee lessens this probability.

There may be economic benefits for the community, a characteristic that is attractive to community researchers and to Health Authorities and Trusts who face the probability of funding DID clients. A clearer understanding of why DID clients behave in certain ways or experience certain feelings may help to reduce time needed in therapy.

It takes time to build trust with participants that facilitates full and honest representation. Short term observational studies can be at a particular disadvantage

where trust building is concerned. However this study is being conducted during on going therapy sessions. I have been in therapy for some years now and 'I' and my 'alters' have already built up a climate of trust with **K** which is secure.

3.4. RESEARCH DESIGN.

McLeod (1999) likens the researcher, when in the process of designing his/her research, to an architect ….

> "…creating a blueprint for a building which will meet the specifications of various groups of people – the property owner, the builder, the neighbourhood, the building inspectors. But once the building work actually commences, unforeseen problems may arise and the design may need to be modified. The notion of the researcher as designer captures well the need for careful planning….. (p72)

I proved McLeod's point here as at the outset I had planned to use heurism and grounded theory in equal proportions when analysing the data. The reality was different. I was unprepared for the strong reaction I had against using grounded theory and the result was that I used one tape for grounded theory. The rest were heuristically processed.

McLeod goes on to say that this analogy is not fully satisfactory for him because many psychology orientated research methods text books

> "…include chapters on research design that are highly prescriptive in specifying a limited set of designs that (in their view) meet the requirements of scientific rigor (the equivalent of the building inspectors)." (p72)

He argues that this approach to design comes too much from a tradition of laboratory experimentation. He expounds the importance to be creative and flexible in practitioner based research. I would concur with this thought for when dealing with people we need to be prepared for the unexpected and change. As a counsellor I work from the foundation of person-centeredness and use integrative tools to help design and build the structure of the therapeutic process together with my clients. I see much of the design of this study following this idea; the foundation being based in a qualitative methodology but also using integrating tools to help form a structure to produce an outcome.

Considerations in the research proposal.
Subject choice
Aims and objectives
Personal significance of the research
Relevance of the study
Literature review
Research questions
Choice of methodology
Method of preparation
Procedures for data collection
Data analysis
Ethical issues
Dissemination of results

Table 2 Research Design

3.4.1 Method of Preparation.

3.4.1.a. Locating and acquiring the research participants.

I have been in counselling for eight years and the one person I trust implicitly is my counsellor (**K**) and when I told him of my desire to continue my research he was very supportive and encouraging and agreed to take part again. We agreed to continue taping my counselling sessions and the implications of this are dealt with in the section on ethical issues. **K** is a participant, 'I' am a participant and so are 'my' alter personalities, **Helen, Simon, Emily**, **Leah** and **Susie**. (see chapter 1)

3.4.1.b. Developing a contract

This included time commitment and place. The interviews/dialogue would take place during already agreed counselling sessions at the counsellor's place of practice as this was an established place of safety for both of us. As I am the researchee I did not need my own permission to record the sessions. However as my counsellor was the other person taking part in the dialogue his permission was requested and obtained. (see appendix A) It was also agreed that should an alter present him/herself during a session then my counsellor would take responsibility to ask permission from them to continue.

K also agreed to be a point of triangulation. As we journeyed through the process I showed him the findings and frequently asked him to comment on them and to offer his perception of the process.

3.4.1.c. Issues of support.

Therapeutic work with clients who have suffered trauma brings the therapist close to the 'soul' of pain, indignity and injury. Working with those clients who have developed the ability to dissociate can lead the therapist deeper into the realms of degradation and inhumanity that can only be otherwise imagined – and to the paradoxical world of chaos and order. In offering the core conditions of empathy, congruence and unconditional positive regard the therapist is further challenged. Achieving empathy requires the ability to project oneself into the phenomenological world being experienced by the client and this empathic stance is vital if the therapist

is to help the client through their experiences and the process in order that they can successfully integrate and reach a point of recognising their true self.

I am aware that working with trauma and dissociation can elicit strong responses in the therapist which can leave him/her with such feelings as helplessness, anger and loss to name but a few. It is essential that the therapist has somewhere to take these and work through in order to protect themselves and their well being and to ensure the continued safety of the client.

K has his own support network, which he has used over the past years of working together in the form of supervision and has other strategies for ensuring his mental and emotional well being and took responsibility for ensuring that this was followed during this research.

My own support came from within the counselling relationship itself. We have been working together for several years now and I am safe in the knowledge that **K** is able to contain and hold whatever 'I' or my alters bring. If I was not sure of this, then this research would not have been considered let alone brought to fruition. Indeed, I would not be working with him. I also have the added support of my counselling supervisor who is aware that I can dissociate and closely monitors my professional ability.

3.4.1.d Appraisal.

It was important that **K** was kept informed as to what I was doing and equally as important that I asked him what his perceptions were during the course of the

research. It occurred as a natural course of the counselling sessions as well as later as a point of triangulation. I gave him my findings which he read and then I interviewed him to discover his views, perceptions and beliefs.

3.5.COLLECTING AND ORGANISING DATA.

I very much wanted the data gathered to be freely experienced and unenginered. I chose the informal conversational interview which relies on the spontaneity of the situation and relationship as this is what person-centred counselling is about. It was done in counselling sessions as part of on going therapy. This approach assumes that 'naturally occurring' talk (Wetherell, Taylor, Yates, 2001) is talk which is informal and occurs outside the context of situations with a declared purpose and particular venue. Paradoxically it can be argued that talk also occurs naturally in more structured situations such as counselling sessions (Silverman, 2000). This naturalness does not refer to whether the speakers are relaxed or unselfconscious, but to the talk being influenced by the presence of a non-judgemental observer or recorder. The presence of the recorder in our counselling sessions had become a natural part of the session procedure by this time as I had been recording sessions for some time prior to the outset of this research.

Each 11/2hr session was tape-recorded in order to report accurately and comprehensively the experience and later transcribed. This was done over a period of two-and-a-half years from June 2000-December2002. This provided a vast amount of material which had to be reduced in order to manage it. The tapes used were randomly selected in that I placed them all on the floor and literally picked tapes out randomly with no prejudice. This way I could not be selective in the material I revealed and

used. Over the 21/2 year period 111 tapes were collected. The random selection of twenty tapes actually produced a good cross section of tapes evenly spaced out in that period. I recognise that this selectioning process could have produced a bunching of tapes in a small period of that time; however the reality was a fairly even distribution. Out of the 111 tapes the following were picked, 3, 7, 8, 12, 15, 20, 24, 28, 32, 34, 38, 47, 54, 69, 70, 72, 78, 89, 94, 109. Each number of tape corresponds to the week in therapy during this 2i/2 year period. Tapes 112, 149 and 179 are the triangulation tapes where work had been given to **K** to read and to then comment on. The transcripts provided themes and essences of the sessions which I think have thrown light on the question and provided the basis for study and analysis. Each tape was subjected to Interpersonal Process Recall (IPR) to stimulate memories of what had been felt and experienced during the counselling session and notes were taken following each session.

I also kept a diary of thoughts and reactions to listening to the tapes and other musings which seemed relevant to this study, particularly in the form of literary quotes that caught my attention or imagination.

I have also been given kind permission by the artist Patricia Karg to use her illustrations which I first came across in the book 'Job and the Mystery of Suffering' by Richard Rohr (1996). They depict so clearly for me the essence of dissociation.

Listening to the tapes became part of my every day tasks and through this immersion themes began to emerge but not without taking its toll. The very nature of the research

and the material covered in therapy was at times excruciatingly painful. I learned too how demanding and time consuming both heurism and grounded theory can be.

The next task was to identify the most dominant themes and to take each one and filter it through the literature, coming to conclusions about each of them and finally to overall conclusions. It was during this time that I recognised that the purely grounded theory method was not allowing me to take into account the nuances, the silences, the voice intonations and the unspoken rapport and understanding of the relationship that I have with my counsellor which are so present on the tapes.

3.6. CRITERIA FOR EVALUATING VALIDITY AND RELIABILITY OF QUALITATIVE RESEARCH

A number of researchers (Guba & Lincoln 1989; Stainback & Stainback 1988) have outlined the criteria for judging the quality of qualitative research that parallel the criteria for judging positivist, quantitative research.

Guba and Lincoln (1994) equate the following

Credibility with internal validity

Transferability with external validity

Dependability with reliability

Conformability with objectivity

For qualitative research they add authenticity.

3.6.1 Credibility = Internal Validity

In qualitative research, credibility asks if there is a correspondence between the way respondents actually perceive social constructs and the way the researcher portrays their viewpoints. Mertens (1998) suggests there are six standpoints to judge the research credibility.

(i). *Prolonged substantial engagement.* There is no rule that says how long a researcher needs to stay at a site. When the researcher has confidence that themes/essences and examples are beginning to repeat rather than extending, it may be time then for the researcher to withdraw from the field. This study was conducted over a three year period from June 2000 through to December 2003.

(ii). *Persistent observation.* According to Mertens (1998) the researcher should observe long enough to identify salient issues, avoiding premature closure to ensure that a conclusion is not reached without sufficient observation. During the three year period of this study there were over 100 counselling sessions recorded. The material produced was vast and to reduce this amount to make the study workable it felt necessary to take tapes randomly from this period and subject these to close scrutiny.

(iii). *Progressive subjectivity.* The researcher needs to monitor his/her developing constructs and document the process of change. Mertens (1998) suggests that the emotional strength of the researcher's findings might leave the researcher biased and that the process should therefore be shared with a peer debriefer.

(iv). *Peer debriefing.* The researcher should engage in an extended discussion with a disinterested peer, of findings, conclusions, analysis and hypotheses. I was able to do this with a good supervisor.

(v).*Triangulation.* This involves checking information that has been collected for consistency of evidence. I have used two kinds of research methods to analyse data, heurism and grounded theory. My findings have then been fed through current literature and contemporary thought. As I have progressed in the process I have also given my counsellor (**K**) material to read and verify and have asked his opinion.

> " The facticity of the research data can only be established by checking it against other sources of information…another method for checking both factual precision and interpretive sensitivity is to take drafts of the research report back to informants and ask them to comment on them."
>
> (McLeod 1994 p100)

K agreed to be a point of triangulation, the aim being to perhaps find agreement about the meanings and themes that emerged in the study or to shine another light on what I had elucidated. I asked him to read each piece of text on the findings as I completed it and to give his thoughts at that stage.

As far as I have been able to find out, there have been examples of case studies that are collaborations between counsellor and client where the enquiry has been conducted after the end of therapy (Mearns and Thorne 1988 and Dryden and Yankura 1992) but I have been unable to find examples of case studies where the actual researcher is the client and not the counsellor and being conducted during on going therapy.

Since I was unable to discover any other research in this field to measure my findings against, it was even more important that my research participant was able to comment on them and add his perceptions to them.

(vi). *Member checks*. Mertens (1998) considers this the most important criteria in checking credibility.

> "The researcher must verify with the respondent groups the constructions that are developing as a result of data collected and analysed. Member checks can be formal or informal." (p182)

This became a part of my triangulation process (See v).

3.6.2. Transferability = External Validity.

External validity in quantitative research means the degrees to which one can generalise the results to other situations. However in qualitative research it is down to the reader to determine the degree of similarity between the site of study and the receiving context. The researcher's responsibility is to provide sufficient detail for the reader to make such a judgement, e.g. extensive and careful description of time, place, context, culture. Qualitative research is more about developing knowledge that is relevant and useful at particular times and places. Hence it is essential for the qualitative researcher to contextualise the study in its historical, social and cultural location (McLeod 1994. p98).

I have provided as much raw data as necessary and have clearly described the research procedure. I have used the literature to feed the data through. Although it is not 100% generalisable I feel it does have real value.

3.6.3.. Dependability = Reliability

Reliability means stability over time. In the constructivist paradigm change is expected but it must be acknowledged and tracked. Yin (1994) describes this process as maintaining a case study protocol. Change of focus is acceptable and perhaps to be expected in qualitative research, but it needs to be documented. My intention at the outset was to use an equal number of the research tapes for both a heuristic inquiry and a grounded theory approach. The reality was different. One tape was used for a grounded theory approach and the remainder for a heuristic approach.

3.6.4. Conformability = Objectivity.

Qualitative data can be tracked to its source and the logic that is used to interpret that data should not be of the researcher's imagination. The researcher's judgement needs to be minimal.

3.6.5. Authenticity.

This refers to a presentation of a balanced view of all perspectives, values and beliefs (Stainback & Stainback) Have I as the researcher been fair in presenting views? Being one of the participants as well as the researcher, helps to ensure authenticity. When analysing data I was able to clarify the meaning of 'my' spoken words which

were perhaps unclear to a reader, an advantage over an observer. However when interpreting transcript from 'my' alters this became more difficult. I had to be aware of their conscious experience of the world. This is where member checks (with **K**) became both imperative and ….. I needed to know that my interpretation of events and dialogue were in keeping with **K**'s experience of the situation. I have also used verbatim quotes.

3.7. ETHICAL ISSUES.

It almost goes without saying that when planning a piece of research ethical and moral issues must be taken into consideration, even more so where counselling research of this nature is involved. As Kitchener (1984) says

> "…the principles autonomy, beneficence, nonmaleficence, justice and fidelity are most crucial for the evaluation of ethical concerns in psychology." (p46)

3.7.1. Autonomy.

Being both the researcher and the researchee I did not need to obtain consent from myself to participate in this research. However it remains a very sensitive area for me, and I needed to be sure that whoever else became involved in the process was someone whom I could wholly trust and who better than my counsellor with whom I have built up an extraordinary relationship of trust as far as I am capable of doing and who has already participated in research successfully with me before?

He has a good understanding of my position and was most encouraging of the project and entered into it voluntarily. He agreed to be a facilitator in this project and a point

of triangulation. Appendix C shows the form of instructions to the research participant and Appendix D shows the participation-release agreement.

There is also for me the issue of this thesis being available in the public domain. It contains very personal material. I am aware that this subject is also contentious and could be potentially exposing. However, I have taken very much to heart the words of Eli Wiesel who survived the horrors of Hitler's concentration camps,

> "The survivor must be a witness. He doesn't have the right to hide behind the façade of false modesty. The easy way would be to say nothing…"
>
> (After the Darkness 2002 p9)

I do not deny I will find this difficult to think that anyone may look into my experiences. It has the potential to resurrect the same exposed feelings I had as a child which induced the dissociation. However I am in a much stronger position today with many people around me who are supportive. I am not that lonely isolated child with no sense of self belief or self value. I think that 'going public' with my experiences will be of benefit to therapists and other DID clients.

As with the previous research there was the issue of consent of any alters who may present themselves during our sessions.

As Bond (1993) says

> 'The accepted practice amongst counsellors is: 'The use of personally identifiable material gained from clients or by observation of counselling should be used only after the client has given consent, usually in writing, and care has been taken to ensure that consent was given freely' (B.7.1). (p137)

K agreed to inform them about what was happening and to obtain verbal consent from them. This had worked well in previous research. If they showed any objection to

being tape-recorded then recording would cease during their presence. Their autonomy is equally important as 'mine' or my counsellor's.

I have also completed the ethics form and complied with Durham University's requisites for the undertaking of research.

3.7.2. Fidelity and Justice.

I recognise that "equal person's have the right to be treated equally and non equal persons have the right to be treated differently." (Kitchener 1984 p49) Where **K** and I were concerned inequality was irrelevant to the issue at hand and therefore treatment was equal. If an alter was present in a session s/he was treated according their age and level of understanding.

> " By the very fact that two individuals freely consent participate in a relationship, an ethical commitment which involves certain obligations for both parties is implied. To some extent obligations to be faithful derive from the respect due to Autonomous persons (e.g. if people wish to be treated as autonomous agents, they Must respect others autonomous rights)" (Kitchener 1984 p51)

Confidentiality is a rule which can to some extent be understood when a client enters into a counselling relationship or in this case a research subject. It is based on trust and respect and unless there is an element of faithfulness in this relationship, the ensuing findings will be invalid.

To protect **K**'s rights and autonomy I agreed that he may opt out of the project at any time and this was part of the contractual agreement.

3.7.3. Beneficence and Nonmaleficence.

Whilst doing everything within my power to prevent any harm and respecting the autonomy of those involved it has been my aim that this research will bring a greater awareness and understanding of some of the feelings associated with living with DID for myself, my counsellor and or those who read the final paper.

Working with trauma based and DID clients poses enormous strains on the therapist of which I am continually aware, both as a counsellor and as the client. Throughout our counselling relationship **K** has always ensured his own well being by engaging in regular and competent supervision where any issues that are raised for him can be explored. It was agreed this would be his continued responsibility to maintain this support.

My support and that of my alters who appeared in the sessions, continued to come from within the counselling relationship. I had the invaluable added support of my counselling supervisor.

3.8. SAMPLING.

McLeod (1994) states that the logic of sampling in case study research is virtually impossible, because of the time and resources required to obtain case data of sufficient quality. However on the other hand the "…logic of replication is central to systematic case study research" (p116) i.e. the conceptual model generated in the first case study is tested in the second and subsequent studies.

This case study could be seen as a sample in itself - or perhaps better described as an example. Maybe, in a future study, the next step would be to do in depth studies of other DID clients.

> "There are situations where the investigator needs to build in to the research design methods of checking on the representativeness of the sample"
> (McLeod1994 p33)

The essence of sampling theory revolves around selecting samples that reflect the larger picture. Having collected the data a random selection of one tape was made and an in depth interpersonal recall (IPR) and study made which when compared and contrasted to the remaining tapes used in the study proved to be very comparable to the overall findings. Although random selection eliminates systematic bias, there is no guarantee that a random selection will be representative of the whole. Each of the tapes in this study is unique and holds individual experiences, yet the sample as with all the other tapes reflects similar emotions and responses. The sample tape proved to be representative of the overall findings.

3.9. THEMES.

As with previous research, the resulting themes of this study discovered in this stage of therapy have been for me both enlightening and considerable and have contributed to my understanding of some of the effects dissociation can have on self. In consequence this has led me to move forward considerably in therapy, freeing me in a sense to face further issues.

As you can probably imagine there were many threads through out this data but I have managed to put them into two classifications bearing in mind that I am looking for the overriding feelings that may be experienced by someone coping with a dissociative identity.

a) A sense of emotional imprisonment.
b) Shame.

It seems appropriate to deal with these individually in separate chapters.

CHAPTER 4

THE ALTERS.

"Man, all too proud, figures that he is master of his movements, his words, his ideas and himself. It is perhaps of ourselves that we have least command. There are crowds of things that operate within ourselves without our will"
(Pierre Janet)

4. 1 THE ALTERS .

I have chosen to leave the introduction of the alter personalities to this point in the study as I felt their appearance now would help the reader to understand and follow the next chapters with more lucidity.

I have often described what goes on in my head at times as "a cacophony of voices". The best description I have come across of how it actually is, was in an essay by Hubert Hermans 'The Polyphony of the Mind: A Multi-Voiced and Dialogical Self.'

He uses the analogy of an orchestra.

> "Anyone who has ever attended a concert is familiar with the musicians tuning their instruments before they start to play. Each of them makes their own specific sound, yet not tuning in to the sounds of the other musicians, and together producing that stimulating cacophony that evokes the expectation of pleasures to come. However, as soon as they start to play, the cacophony is transformed into a well-organised composition of consonants and dissonants, that can only be produced by musicians who respond to each other in precise and structured ways."
> (Hermans 1999 p107)

He goes on to talk about how Bakhtin, developed the thesis that the author Dostoevsky created a new form of artistic thought, the polyphonic novel.

> "Its principal feature is that it is composed of a number of independent and mutually opposing view points embodied by characters involved in dialogical relationships. In playing their part in the novel, each character is ideologically authoritative and

> independent, that is, each character is perceived as the author of his or her own view of the world, not as an object of Dostoevsky's all-encompassing, artistic vision. Instead of being 'obedient slaves' in the service of Dostoevsky's intentions, the characters are capable of standing beside their creator, disagreeing with the author, even rebelling against him. It is as if Dostoevsky enters his novels wearing different masks, enabling him to present different and even opposing views of self and the world, representing a multiplicity of voices of the 'same' Dostoevsky"
>
> (Hermans 1999 p108)

Bakhtin's metaphor of the polyphonic novel sees the writer stepping back from that traditional role of author. He becomes part of the text giving up his position of privilege and taking on the role of one or more of the characters, often with contrasting world-views. At times, these characters enter into dialogical relations of "…question and answer agreement and disagreement so that new constructions may occur."

I am left wondering if Dostoevsky had experience of what it is like to live with dissociated parts.

These voices and instruments are excellent metaphors for what happens inside 'me'. I think it is apt that the reader is given some background to those alters who play a part in this research

4.1.1. Helen.

Helen is 7years old. 'I' see her as the informant. She seems to hold knowledge of the other alters. She is a very nervous child who also took a long time to build up a relationship with **K** and always addresses him as **Mr K**. (Tape 70, sees **K** talking her through a panic attack). She has a twin, Mickey, whom she hides as she is afraid he will get them into trouble. He is mischievous. She is inquisitive and seems to have a

thirst for knowledge. She wants to know the ins and outs of everything. I suppose 'I' identify closely with her. She has often asked questions of **K** feeling safe enough to do so knowing that she will not be ridiculed for asking silly or "the wrong" questions. I suspect she is also the risk taker.

She has at times put **K** on the spot asking somewhat awkward and often intimate questions, which he has tried to honestly answer at a level of her understanding. There was a particularly painful few sessions where **Helen** talks about her confused sexuality because of the mixed messages she receives from her abusers. There are obviously questions that she has but has never been in a position to ask them. There has never been anyone with whom she has felt safe enough to talk to until now.

H. Why am I a girl?
K. You're a girl because that was the way you were born sweetheart…..you didn't have any choice over being a girl just as I hadn't a choice over being born a boy. We don't have any choice in that……Our mams and dads don't know what we are going to be until we come out.
H. Come out?
K. You come out of your mam…out of your mam….as a baby.
H. Did I come out of my mummy?
K. Yes, you did…..not…yes you did…..I came out of my mammy!….We all do….when we are little tiny babies…..(silence)……..(Huge sigh from Helen)
K. Uh huh…What was that big (K imitates Helen's sigh)…..forMmm?….(silence)….
H. Did I come out of my mummy?
K. Yes you came out of your mummy…..(silence)…(said in a side whisper…I'm just thinking to myself here, what's this leading to…just keep going and see)…(silence)…
H. My mummy didn't want me so why did my mummy have me?
K. Now can you tell me what you mean sweetheart when you say your mummy didn't want you…and why did your mummy have you?
H. Mummy…she never wanted me…so…
K. Did your mummy actually say that to you…that she never wanted you?
H. She always says it….I shouldn't have had you.
K. Well…sometimes women have babies and don't want them….but they have them.
H. Why?
K. Because they think that because a baby is growing inside of them…it would be wrong not to have the baby…so they have the baby.

A little further into the conversation

H. How did the baby get in there?
K. Well…um…
H. Why do they put them in there?
K. Well they grow inside…because that's the place inside your mammy which is made for babies…for growing…….(long silence during which time 'I' get a sense of Helen really thinking)……
H. Did my mummy swallow me?
K. No she didn't swallow you sweetheart…..(another silence)…..
H. I don't want babies…..(side whisper from K…I'm doing an avoidance job here…following the path of least resistance, Helen notices)…Sorry I'm just talking to myself. I do that sometimes. It helps me remember things.
H. I talk to my teddy.

(Tape 72)

The conversation continues and **K** gives answers and explanations to questions at **Helen**'s level of understanding. There are many occasions like this when she has felt able to talk quite openly and intimately to him showing the child like innocence and qualities that 'I' lost so early. Perhaps they remain in 'me' through her.

Listening to the tapes with **Helen** on, I sense a process going on. It is almost as if in answering her questions, in taking the time to be interested in her story and how she thinks and feels, and in engaging in normal dialogue with her, he is doing the parenting that she/'I' so obviously missed out on as a child.

In the following quote **Helen** has been taking notice of the things in **K**'s consultancy room. Here she has spotted his business cards in a holder.

K. You can put a whole lot of cards in because you…you do that….and the wheels move up…I didn't know that was stuck on the bottom there!…and those cards are when people come and see me and they make another appointment and I write down the time on the cards….uh huh…all right?…Can you read what it says?
H. The r…c…(have not identified the place)
K. Uh huh.
H. I don't know what that is.
K. That says counselling.

H. What's that?
K. Counselling is when two people talk together…one person is sad or upset and the other person helps the one who is sad or upset to make things better.
H. Can you do that?
K. Yes sometimes…not always…sometimes…Can you read the other word for me?
H. Train…..
K. Train….

H. …ing.
K.Train….training….uh huh…It's another word for teaching…teaching someone to do something.
H. Is that making them do something?
K. No it's not making them do something. It's teaching them how to do something if they want to do it. It's not making them do it if they don't want to.
H. My uncle says I have to be trained.
K. Uh huh…Does he?
H. (trying to read something else on the card)…Hum…..hummmmm…..an….
K. Human…
H. D…d…devil…
K. Devel…
H….human devel…op…
K. Human develop…?
H. …ment……..
K. Can you say that word for me? Development. Yes?
H. Human development.
K. Human development….is helping people, human beings like you and me …um...helping them to become…what they want to be…um...helping them to grow…helping them to learn things…helping them to…
H. Do you help people to grow?
K. Yes I do…
H. How can you make people grow?
K. Well I …I don't make them grow in….
H. You have to eat your tea!
K. …(laughing)…in height and width like that…I just help them learn new things…learn how to do things.
H. My uncle trains me.
K. Uh huh.
H. He trains me to do things.
K. …does he ask you if you want to do the things he's training you to do?
H. No….I have to do them.
K. You have to do them.
H. …because I'm a child……You don't ask children. You have to do as you're told.
K. Uh huh…I ask children….If I was training you to do something I would always ask you if you wanted to do it….and if you didn't want to do it I would say that's OK. You won't have to do it in that case. (Tape 3)

Sometimes it feels to 'me' that maybe **Helen**'s integration will come when she has been brought to maturity through this process. 'I' see a blossoming of her character that 'I' mourn for 'me'. It could have been - should have been so different.

She is opening up to him at a level that astounds 'me'. She says things and tells him things that 'I' would not be capable of. I rather suspect **K** finds **Helen** quite engaging as there have been teasing innuendoes fed to her for 'my' ears, a measure of the ever continuing, developing relationship of trust between **K,** the personalities and 'myself'. She often speaks in an almost inaudible voice and he has to ask her to repeat what she is saying on many occasions.

K. Sweetheart, I'm really struggling to hear you darling,….I'm trying to listen to you and I want to hear what you're saying. You'll have to speak a little louder for me……sorry, when you get to my age, you don't hear all that well you know?…..because I'm really old remember!

(Tape 70)

We are both the same age!

Helen is a character growing in confidence and ability, which I think, influences 'me' in a subconscious, positive way. She tests waters that 'I' never dared do in the past but am beginning to do now. It feels that **K**'s work with her is having a positive influence on 'me'.

One of the things I became aware of while doing the research for the MA was that my dissociation, is both a coping and a defence mechanism. It is a way of coping with an intolerable feeling and a defence mechanism designed to retain some semblance of sanity and indeed life itself. According to Lazarus (1999) coping it seems, has to do

with the way people manage life conditions that are stressful and he talks of coping in trait/style and process. Trait/style is interesting he says because

> "....it has to do with treatment strategies of clinical psychology and psychiatry. Cognitive therapists, for example, consider chronic adaptational failures to be the result of stable pathogenic ways of thinking. (Lazarus, 1989b). It is reasonable therefore, to assume that these ways of thinking must be changed if the troubled person is to function better.....Ego psychologists, such as Karl Menninger (1954) and Norma Haan (1969), viewed coping and defence as reflecting a hierarchy of
>
> health and pathology. Coping was said to be the most mature way of dealing with stress or trauma. Defences were regarded as neurotic or psychotic efforts to adapt because they departed significantly from reality." (p103)

The question I beg to ask is "How would they view dissociating – coping or defence?"

Is this not an example of defence being coping? Is it mature or psychotic?

There is, as I see it, one big limitation of the trait/style approach to coping in that it reduces coping to a contrast between two ends of a spectrum and almost denies and certainly underestimates the ingenious methods that people go to, to survive stress and trauma.

In dissociating from a painful experience I suppose I am not working through in a conscious way, the significance of the stressful/threatening event but what I am becoming increasingly aware of (and I think too, that this is majorly significant) is that this does not prevent these memories and experiences from affecting my behaviour and self concept. So the negative experiences which caused the dissociation to occur in the first place and which continued to subconsciously affect my thoughts, perceptions and beliefs are gradually being replaced or usurped by the positive experiences that the alters are receiving in their relationship with **K**. It feels as though

my subconscious and conscious is being re-educated. The more I listen to the tapes with **Helen** and **K** and recognise changes in my daily life, the more I have belief in this theory. Like **Helen**, 'I' am more at ease in asking questions, particularly in public than I was even a year ago. I am learning that I have both the right to ask and question and that it is OK to do so. My confidence and belief in self are growing. Now that I call movement.

4.1.2.Susie.

Susie is 11years old. 'I' see her as the bridge between the younger and older alters. She is a shy, quiet girl who took some time to build a relationship with **K**. She suffered multiple abuses, which led her to splitting into another personality, **Emily**, whom she carries around and of whom she is extremely protective. Like **Helen** she is inquisitive and observant and has a sense of humour that **K** responds to. It seems she has an almost love for **K** as she is the only character who smiles at him, something he often comments on.

Figure 4 Alter helping Alter

K. You have a lovely smile….your whole face lights up when you smile. (Tape54)

He has brought something out in her, which, as far as I am able to see, has not been brought out in the others, at least not to the same extent. Her trust in him is almost indomitable to the point she can almost relax. She is able to relate her abuse in detail, telling distressing events with a kind of knowing that she will be received with total

belief and tenderness. As far as I can see from listening to her over the months/years, there was never a moment of tenderness in her experience and she responds to **K**'s gentleness in a way that actually frightens 'me' at times – unconditionally. Perhaps there is a measure of a child's ability to believe in the good side of life still in her, whereas 'I' am more sceptical - but slowly beginning to accept too.

During one session **Susie** relates a particularly distressing incident and the measure of her trust in **K** is very evident. It seems she understands she will be received with kindness and attention. She is talking about an incident when she was 7yrs old where because she had not said thank you for her tea she was made to stand in the corner of the hall for a weekend and it appears lost her power of speech for some time. Despite everything she opens up to him.

S. It hurt.
K. It hurt….and it sounds like it hurt so much…It hurt awfully…and it hurt so awfully that you wanted to die?….Am I hearing you correctly Susie?
S. Mmm….(long silence)….I had to stand in the corner…I can't…I don't…there's nothing to say.
K. There's nothing to ?
S. There's nothing to say.
K. There's nothing to say…and you….have to stand…Susie let me just check again….you have to stand because it hurts so much?….No?…..Do you have to stand because….
S. I can't talk.
K. You can't talk?….Sweetheart are you saying you have to stand because you can't talk?….OK.
S. There's nothing to say.
K. There's nothing to say…..yet Susie…I'm….I'm aware that you talk to me…Mmm?
S. Mmm.
K. Is that because you have got something to say to me?
S. Because you listen.
K. I do listen…so it sounds like you had something to say to someone who would listen to you?….Do you understand what I'm saying to you?…No?…OK….You…you said to me that…that when you were talking it was because you had something to say …Mmm?…and then I said to you, well you talk to me…and you said to me that's because I listen…so you talk…when someone will

listen to you then you will talk…is that right? Do you understand?…No?….If you don't understand tell me…because I don't always speak clearly.
S. I used to…if I say…I get hit.

A little further on she tells of not talking at school

S. Go to school.
K. Uh huh.
S. Don't speak.
K. Don't speak at school?…(long silence)…..
S. I have to stand in the corner at school
K. You have to stand in the corner at school?…Is that because you won't speak Susie?…and you won't speak because you've nothing to say….I'm just wondering if….if there was no-one listening to you there either?…Mmm?

(Tape 24)

Like **Helen** she, too, can ask questions of **K** with a freedom and an innocence that comes with a tender age. She also reveals her inner thoughts and feelings almost in a confessional way that, **K** always validates and at times identifies with, often reinforcing her right to her thoughts and feelings by revealing he would have felt the same in her position.

In the following quote **Susie** has been talking about some lines she had to write at school that she did not understand "Hurt feelings are an indulgence in self love".

K. …and you don't know what that means….That sounds like they are being stupid to me…Do you know what I mean?…The teacher who's making you do that sounds like a…stupid to me.
S. Sister I.M.
K. Sister I M….I don't think I like Sister IM….

The conversation continues with **Susie** asking **K** what indulgence means and he gives a very adequate explanation for an 11 year old and she engages in the repartee. She very child-like reveals that she knows that Sister IM doesn't like her.

K. No I can imagine she doesn't like you…In that case I definitely don't like her because I like you!…Now if she doesn't like you I certainly don't like her….because I don't….find you difficult to like…..We get on you and I don't we……(silence)…I'll remember that, hurt feelings are an indulgence in self love. I'll have to make sure I remember that.

It feels to 'me' that **K** takes on a teaching role on many occasions with the personalities, offering them answers to questions they have so far felt unable to ask. I get a sense of them receiving both an education in academia and also in 'life'. It somehow feels he is raising them – bringing them up. In his acceptance of them lies, I think, the key to their integration.

He offers **Susie** the understanding of her thoughts and feelings. She is a child, harbouring child like thoughts and feelings and feeling guilty for harbouring them. He reassures her that she is not alone in her 'guilt'.

K. Your mother wasn't a very nice woman.
S. Shhhhh!
K. She won't hear you. Your mother wasn't a very nice woman Susie….um…that's my opinion…She doesn't sound like a very nice woman.
S. Everybody likes her.
K. Everybody likes her. Do you like her?…(silence)….Mmm?
S. I have to like her.
K. Oh! (said with frustration)…I didn't say you have to like her! I said do you like her?
S. You won't tell?
K. I won't tell…A will know because she'll hear us on the tape…nobody else will know.
S. But it's wicked.
K. What is?
S. Not liking your mum.
K. Uh huh. Who says?….I like my mum because my mum was a very nice person…she was a lovely little woman…she's dead now. She was a very nice woman and I liked her. I don't think I like your mum…she doesn't sound like a nice person at all.
S. I don't like her.
K. You don't like her…you don't have to whisper. You can say it, that you don't like your mum…Mmm?
S. But it's wrong.

K. Is it? Who says?….(voice indignant)…
S. I have to honour and obey….
K. Ohhhhhh!…(sound of exasperation)
S. …and be nice…and good….I hate her!
K. .(laughs).You hate your mother. Right….You hate her. (Tape 24)

K has given her a medium to talk freely and accepts everything she says without blame or censor. At no time does he ever suggest that what she says or feels is wrong. Listening to the tapes leaves me with a sense of injustice and anger that 'I' have spent 'my' entire life with this guilt and shame that 'I' harboured such thoughts and also a great sense of gratitude to **K** for accepting and giving **Susie** the permission to have her feelings without conditions attached.

There is a sense for 'me' that the interaction with **K** is teaching the personalities the positive experiences they have never received. In turn this experience is acting positively, if subconsciously, on 'me'

Susie has found her voice with **K**.

There is an alertness and sensitivity about her that is often painful to listen too. It feels as though she is always on her guard, almost waiting to be hurt again yet at the same time the level of trust and risk she takes with **K** cannot be mistaken.

4.1.3. Emily.

Emily is 14 years old and as far as I can make out is the most damaged by her experiences. She too, endured multiple abuses. She is extremely timid and frightened by the slightest noise. She struggles to communicate verbally and cannot walk. Her ability to trust is almost negligible although there are signs of it beginning to appear.

Her medium of communication is often through the use of buttons, which she found in a box in **K**'s room. It is through the use of these buttons that she has been able to tell **K** her story. 'I' get a sense that she has been totally crushed by her experiences and it will take a long time for her to recover and reach any semblance of normality. She is fiercely protected by **Susie** who carries her around. She usually only appears when brought by **Susie** but has on one occasion appeared through **Helen**. When present she hides behind her 'tree', a large plant in the consultancy room. It has taken a lot of patience on **K's** part to slowly entice her out from behind it. Sometimes he is successful and other times not.

Emily was subjected to ritual abuse and tells her story in monosyllables and short phrases backed up with the use of the buttons. At one stage in a session **K** uses a side whisper (reported in brackets) to describe what **Emily** is doing.

K. Which man is this Emily?
E. Doctor.
K. He's the doctor did you say?…OK…(another brown button)…Emily….tell me about those buttons please will you… sweetheart?…(more large buttons…one brown…another brownish…and another one greenish…and again bigger buttons than…in a circle around the smaller buttons that represent the babies…which she's picking up now…leaving the red one…putting it down outside of the circle…taking many more big buttons…all brown buttons and really done with anger …and the pointed implement has been put on another brown button pointed at the small brown button representing one of the babies…she now has a large metal bolt in her hand…and she's standing it in the middle of one of the circles, standing it next to the button representing one of her babies…incredible power imbalance…the power imbalance is overwhelming….my interpretation…I may be wrong but I don't think I am… Another black button) ….Emily what are those little black buttons?
E. Me.
K. You…OK sweetheart…you…(diminutive, tiny…tiny surrounded by these large) Emily what is that sweetheart?…What is that? (Tape 7)

Figure 5 Examples of Emily's use of buttons.

It is through **Emily** that 'I' began to understand that it would have been impossible to have even contemplated doing anything about what was happening to 'me' as a child. It was a violent world 'I' lived in and 'I' was very small in that world. The result of revealing the abuse would no doubt have ended in more violence and who would believe what was happening anyway? **K** has often commented on how struck he has been all through our relationship about the imbalance of power. Being able to revisit the tapes is slowly helping 'me' to accept that maybe 'I' was not responsible for what happened and that the enormous sense of guilt that 'I' carry around is not justifiable. I know my seeming inability to do this frustrates **K** at times.

Here he has been telling 'me' in brief what has happened in the session.

K. Well…(laughing)…again it would be good if we had a video of this just to see…where…you may lose a good bit of this….part of the action took place over there..(indicating the other side of the room)…it was Susie sat in the chair……and then worked with Emily who wanted to work with the buttons and she shuffled across. She can't walk…and she doesn't want me to ask why she can't walk…but again what she was doing with the buttons was graphic…and what….what she's depicting using the buttons was an incredible power imbalance….incredible violence…and oppression. (Tape 7)

It seems to me that when you listen to **Emily**'s story it is small wonder that 'I' dissociated. How could a child so crushed survive to function with some semblance of normality and sanity without recourse to extreme measures?

In later sessions **K** again talks of the power imbalance in **Emily**'s portrayal with the buttons.

K. . ….(an incredible scene of buttons and a bolt. The sheer power imbalance as I've indicated before…is almost indescribable) (Tape 38)

K. Yeah…I mean I've said to you several times…what's conveyed by that to me is the power imbalance…Yeah…and the brutality…I mean I've heard the brutality over the years…I've seen what happens to you when you talk about it etc…but to see it like that …you know just…lights it large for me in a sense…I mean what you've got here is…is tinyness….profound fragility….um…just dominated by….these brutal people. (Tape 47)

There is a sense for me, listening to the interaction between **K** and **Emily**, of their relationship giving 'me' a kind of permission to 'walk free' in the world. **Emily** is, it seems to 'me', the epitome of terror. She, like some of the others, has never been able to cry or indeed show any kind of emotion. Through her relationship with **K** she has begun to at least look at the idea of expressing some of her suppressed feelings. Any feelings she had were kept inside. When **Emily** describes an incident it is obvious to **K** that there is something else going on for her.

K. …is that what you are telling me sweetheart? S is hurting you?
E. Mmm.
K. Is he?…What would you like to do Emily?
E. Screaming in my head.
K. Excuse me?…Emily I can't hear you darling.
E. Scream….in my head.
K. Sweetheart will you say that again. I'm sorry I'm not hearing you well…could you say it to me again.

E. Scr….eam…
K. Screaming in your head?
E. Mmm.
K. Would you like to scream out loud……..You are screaming in your head…no noise…nobody can hear you screaming in your head…Mmm?….
E. Noise….mustn't noise….
K. You mustn't make any noise?….Are you screaming loudly in your head Emily?…It almost sounds like it wants to come out Emily….Mmm?….Does it want to come out?….Does that scream want to come out Emily?…Would you like to be able to scream?…Mmm?…. Nobody will put their hand over your mouth here Emily. You can scream here Emily if you want to…I won't stop you….Would I? (Tape 15)

In inviting **Emily** to let go of some of her pent up emotions, it feels to 'me' that **K** is telling her that it is OK to feel, that nothing will happen. It is acceptable. I get a sense that in **Emily** learning to be able to allow her feelings out then 'I' will be free to do so too. I see **Emily** and perhaps **Leah** as the keys to unlocking the freedom to feel in 'my' own right. It is her personality that mostly illustrates this research. She is the one who epitomises so much loss.

4.1.4 Leah.

Leah is 26 years old and the definite voice of anger, no - rage. She does not reveal her presence often but when she has there have been some revealing exchanges. It would seem that **Leah** has appeared in the past in circumstances where suppression of anger was just impossible. Although quite scathing at times of **K** she has so far bowed to his authority. **Leah** is the personality 'I' am most frightened of. I am not sure what she would be capable of if aroused to full height. She is a paradox because on the one hand she comes out to protect the other personalities, yet on the other hand she has declared them as "stupid" and "wimps". (Tape 69)

Her real hatred can be heard during a session, which reduces **K** to tears. She is recalling an incident and then goes on quite explicitly to let **K** know how she feels about the men who abused them.

K. You'll kill them all.
L. I'll kill you all….don't come near…I'll kill you all.
K. I believe that.
L. I want you all to die…I want to die!
K. You want to die?
L. I'll take you with me.
K. Me as well?
L. If you stand in the way I'll take you with me…..No…(starts to cry)….No….I just want…I…I..I want them all to die…I want them all dead.
K. You want them all dead …They've all got to die….OK…Why have they all got to die?
L. It'll stop….all the hurt…
K. OK.
L. No more pain.
K. No more pain.
L. I want them all to die.
K. I can hear you loud and clear….I'm listening….

The conversation goes on with **Leah** becoming more explicit in how she wants her abusers to die. **K** accepts everything she says without judgement.

K. Leah….Leah…I..Leah…I can hear what you are saying. Could you listen to me for a moment please?…Leah….Now there's no need to look at me like that because I haven't done this to you….They have done this to you. I haven't done this to you. I am on your side….(almost in tears)…..
L. Nobody's on my side…(almost in tears)…
K. Yeah, I'm on your side!…(said with emotion)…I'm on your side…You ask Susie…ask Simon…ask Emily…who's side I'm on…and if I'm on their side I'm on your side….
L. You won't send me to prison.
K. I won't send you to prison…No…last place on God's earth I'd send you…no…I'm not going to send you anywhere darling….ask Helen who's side I'm on…Ask them all have I ever hurt them?…I guarantee they'll tell you no…Now I've got no desire to hurt you…if I'm not going to hurt them, I'm not going to hurt you….so yes hate them….just don't lump all men together…cos there are some good ones…and I'm one of them…and I mean you no harm…now you mightn't believe me…but it's still true…….You're welcome here….like all the others. I don't have

favourites among you…and if you want to talk to me you can get as angry as you want and you can talk….talk in whatever language you need to talk in…no problem.
L. I hate them!
K. Yeah I can understand that …and if you want to kill them, you kill them. Don't kill me because I'm not one of them. Now you mightn't believe all that because I know how you feel about men…I'm different…Nobody ever gets hurt here…you or anybody else. (Tape 89)

Through her encounters with **K** it seems that **Lea**h is beginning to learn that not all men are the same.

Much of her anger is directed at herself. She feels guilty at not having done anything to prevent the situation or to put a stop to it. There have been many encounters where she has vented her frustrations and guilt. They are painful to listen to and have often brought **K** to tears.

Leah is the character that **K** most identifies with. He says that he understands her anger and has often described it as justifiable anger, anger she has a right to,

K. What do you think about those men Leah?
L. I hate the bastards.
K. Yeah… yeah …and you've got every right to hate them…Nobody can take that right away from you. (Tape 89)

4.1.5 Simon

Simon is 9 years old and as his name suggests, a boy. It seems he was created to satisfy the homosexual needs of some of the abusers and their desire for boys. There were times when their derision of girls was unbearable. He endured much physical pain and as a result stutters. He is also a protector of the younger girls sometimes, it seems, taking over when something became too much for them to handle. He is

nervous and cautious when talking to **K** and this may well be as a result of his experience of men. He does not often appear but when he does he leaves 'me' with a sense of rage that lasts for days.

There are times when his stuttering is worse than others, yet **K** very rarely attempts to finish words or sentences for him. I have to say when listening to the tapes of Simon 'I' am torn between pity and irritation and am often wanting to say the words he stumbles over for him. He is the character who needs to be listened to in order to get a sense of him. Reading transcripts of his conversations with **K** does not do him justice. You cannot get the same sense of anguish from reading them as you do from listening to his voice. **K** has often said that videoing sessions would provide so much more than even the audio tapes provide. There is much to be witnessed in the visual, the nuances, the body language, what passes in eye contact.

K shows remarkable patience where **Simon** is concerned and often takes great pains to reassure him when he gets frustrated and spends time checking out what he is saying.

Sm I…am….h…h…help…help.
K You help.
Sm Su…s….Susie….l……le….legs…nu….numb.
K Susie's legs are numb…because of standing?....I understand
Sm I….I…h….help…..help.
K OK. How do you help Simon?
Sm When….when not looking….kn….kn….kn..kneel.
K Take your time, I'm listening.
Sm Kn….kn…kneel. C…an't sit.
K Simon let me just check out what I'm hearing here. You help Susie by kneeling….I hear you say you can't sit…. (Tape 24)

There are other personalities whom I have not introduced to the reader. That does not mean they are unimportant, simply that they do not appear on the tapes which have been randomly picked for this research.

4.2. TRIANGULATION.

Having written about the personalities that appear in this research it felt important for **K** to read what I have said. I wanted him to make his observations and to either concur with what I had written adding anything he felt I had missed or not seen, or to perhaps even dispute what I had said. Would he see the personalities differently? Would he experience his relationship with them as I observed from the tapes or would he confute my observations and felt sense? His response to this was far more important than I had imagined. If I was way off course from his experience of them what implications would this have on our relationship and for future therapy? Waiting for him to read it and come back with his response was an anxious time. However my fears were unfounded. He was very affirming of my formulations which I think demonstrates the depth and understanding of 'our' relationship.

K What do you need from me A ?
A Just your observations…I think…on what I've said about each of the different personalities….How do you view them?
K Well I support everything you've written. I think you've written….I think you've viewed them very accurately…you…very accurately indeed…..You present them very well…Your presentation of Leah, for instance, is a very sound presentation. You pick her up very well….You sum it up….a brief summary, yet it is very accurate…and all the others as well.
A Because all that is supposed to do is to give the reader some insight …um…which of course I didn't do for my MA….I mean I was very cagey…it was one of the things M (MA supervisor) said …she said "The only real criticism I have of your MA is that you don't introduce us to your characters". She said "You are very cagey" and I said "Well with good reason"….um...and she said well this time you really need to…because this time it's really important the reader. particularly in qualitative research has an understanding of who the participants are.

K Yes sure.
A Which is why I talk a little bit about you……as long as you feel that's accurate.
K Yes I do…..It's very accurate A.
A ..and you don't mind anything I've written about you?
K Not at all. No…….I think it's a very accurate presentation of our work.
(Tape 112)

Reading this chapter brought **K** to looking at his own participation in the relationship.

K What I am struck by enormously is seeing my intervention in written form…and your reflection on my interventions….They are quite striking for me….I hadn't thought of them as having that much impact…and I hadn't thought of them having as much impact as you say they have on the others…you know?
A And I'm only going through what I can pick up on the tapes….because 'Im' not them
K Oh sure….
A ..if you see what I mean. (Tape 112)

There follows a conversation around my observations and reflections on the personalities and the process we are engaged in and **K** comments on the "powerful insights" he feels that have been made and reflects that seeing it written down is "very striking" for him. He also recognises that the way in which we are working is bringing about a form of integration which although not perhaps the 'conventional' way. however is invaluable to me.

K It seems to me that whether we want to give it the name or not….there is a kind of integration going on within each of the personalities….you know…that they are…what I hear you saying…..that what I hear you saying in this is that…there is a growing up taking place in each of them…although I get a sense this is not the kind of thing the theorists talk about, which is them being integrated into you….that they are being integrated into themselves. (Tape 112)

What I find so reassuring and which gives me the confidence to carry on is that **K** recognises that in working in the way we are with 'me' and the 'personalities' there is a process – a growth – towards some sort of satisfactory outcome.

K Yes sure…..and it seems to me that it is the kind of process that must take place if any kind of…healing…or whatever meaning we give to that, is to take place. It's the kind of process that must take place if these little ones and bigger ones must be engaged with at a meaningful level so that they do have …like for instance the situation whereby….where are we…yeah...it's um….(looking through the transcript)….it's the one further on here …is it Helen talking about hating her mother….which….it could be Susie…(silence…looking for the piece in the transcript)…..yeah this is the one…..

(Tape 112)

K talks through the transcript here of **Helen** hating her mother. and how important it is to accept her thoughts and feelings in order for her to accept herself.

Finally there is a conversation around how listening to the tapes is so important as much is lost in the transcribing in the way of voice tones, pauses, nuances and the

A…unspoken depth in it actually.

K Oh I'm sure of that!

(Tape 112)

CHAPTER FIVE..

CHAPTER 5

RESEARCH DISCOVERY. – 1 - A Sense of Emotional Imprisonment..

"If a man will begin with certainties, he shall end in doubts; but if he will be content to begin with doubts, he shall end in certainties."

(Francis Bacon)

5.1 INTRODUCTION.

I think that whatever research we embark on there will be preconceived ideas as to some of the possible outcome. This was the case with my research in 2000 and again at the outset of this study – perhaps more so this time with the experience of my previous research. As before, some of those pre-notions were evident however, yet again there were some surprise findings for me.

5.1.1 The Preconceptions.

There were several factors which influenced my preconceptions. I live with DID on a daily basis and have done so for as long as I can remember. It is therefore only to be expected that I would have some pre-notions. I have also been in counselling for some time and this too has meant that I have developed quite an understanding of my life and have worked through many issues. In addition to these I have already done some research in this field and have findings relevant to that stage in therapy. At the end of that research and because therapy was on going I was beginning to predict what might be the outcome of further research. This was something constantly in my awareness as I did not want it to colour the findings of this study. However, one of the advantages

of using tape-recordings is that there is the opportunity to revisit sessions and explore them in depth and this provides huge advantages over having unrecorded sessions. Firstly, it is often difficult to remember everything that is discussed in sessions and the effects and outcomes of those discussions so recording the sessions lessens the chance of missing important material. Secondly, and this is very important when looking at DID, it gave me the opportunity to meet and hear 'my' alters. I do not have co-consciousness with my alters so consequently rely on **K** or the tapes to let me know what has taken place. However some of the alters know each other and are aware of the existence of others. Thirdly, it helps dispel any tendencies to make assumptions or predictions.

My dissociation is the result of prolonged and systematic childhood abuse and adolescence, and again in this study there have been times when it has been difficult to distinguish the feelings I manifested as being a result of this abuse or as an effect of the subsequent dissociation. Inevitably the two were often interlinked and indistinguishable.

The counselling process continues to bring times of great incomprehension coupled with elements of fear, a sense of loss, powerlessness, disbelief, despair, and chaos, fear of abandonment, suspicion and issues around trust. These were all elements that I expected to find. The MA research highlighted other areas, an inability to allow 'myself' to feel at any real depth, a lack of sense of self and reality and a fear of not being understood linked with a sense of indignation and frustration around the use of language associated with DID and abuse. While some of these emotions still exist I

have come to some understanding of them and am now further down the road of therapy.

The key differences between the MA and this study are

1) The MA was a minor study conducted over a short period of ongoing therapy. i.e. over two months. This research has been conducted over a period of two-and-a-half years of ongoing therapy.

2) Data gathered is from sessions further down the road of therapy and therefore I have greater insights into DID and its effects.

3) There is greater co-operation from the alters in this study and they are willing to participate more fully. I am in a unique position in having transcripts of the alters in therapy sessions to work from. Their contribution to this study is invaluable. They introduce material that is more objective than purely autobiographical.

5.1.2. Difficulties Encountered.

The greatest difficulty for me in this research was not so much having to sit with the discovered knowledge of the past and what happened, although this was more than tough at times, but having to analyse data that I had moved on from in the therapeutic process. Going back and revisiting perceptions, responses and emotions that had been worked through in the therapeutic process was at times enormously difficult from a different standpoint. Allowing myself to go back and bathe heuristically in material I had acknowledged in sessions and worked through to a point of acceptance and assimilation was often painful and I had to discipline myself to not allow what was a present stance to colour the investigation of a previous one. It was also difficult not to

allow myself to be taken back and wallow in self pity! There were times too when I found myself making judgements and criticisms about myself and my past perceptions.

Another complexity was listening to the alter personalities express their feelings and understanding that these were facets of 'me'. The fact that 'I' do not allow 'myself' to feel at any real depth is still very evident as they appear when things become painful or difficult to handle. They have been created to shield 'me' from depth feelings. 'I' have done my feeling through 'others'. It was like listening to other people yet they were in reality 'me'. It confirmed what I have thought for some time that I had only existed – not lived. Dissociation was, and still is, a way of disowning, denying and disconnecting from fear and pain. In a sense it locks 'me' away from myself. Perhaps the key of therapy for me is to bring an ability to experience emotions/feelings into 'my' consciousness – in other words to learn to cope emotionally without recourse to dissociation. Perhaps for me this is the "integration" that clinicians and theorists talk about. (Mollon 1996: Herman 1992). Perhaps this is a freedom.

Researching myself at times brought with it its own difficulties. Keeping my research persona to the fore required a discipline of itself. Here I had the expert help and advice of both my counsellor and participant **K,** who was well aware of and supportive of this research and kept me centred and able to keep therapy and research discussions separate, and my supervisor who with his academic experience and input kept me focussed. There were times, particularly at the beginning of the study, when the alters were unsettled and I found it difficult to concentrate. I had periods of dissociation too. During these periods I took time out to relax and re-engage. As the

study progressed these periods of dissociation diminished. This may be due to the alters being more trusting of the process and also to the process of therapy.

Chapter 3 outlines the methodology in detail. However it does not seem to hurt to remind the reader that the heuristic approach of immersion in data with the aim of reaching a creative synthesis is an eminently efficient method of discovering the findings as is also the grounded theory approach. Both approaches allowed for a dawning or breakthrough in the realisation of feeling a sense of emotional imprisonment and that shame is a key to that prison.

5.2. A SENSE OF EMOTIONAL IMPRISONMENT.

"Freedom comes slowly at first"
(B. Keenan.)

"…you will come to know truth,
and the truth will set you free."
(John. 8:32)

Acknowledging a sense of emotional imprisonment from the data led me to exploring literature from others who have experienced imprisonment of one sort or another.

This was the theme that elicited a sense of anger within 'me' and this was a new sensation. There was a dawning for me of the injustice of abuse and the consequent dissociation – of how the perpetrators prevented me from having a 'normal' life and how they changed the 'natural' course of my life. Frankl giving account of his time in Auschwitz, said

"At such a moment it is not the physical pain which hurts the most…..it is the mental

> agony caused by the injustice, the unreasonableness of it all. Strangely enough, a blow which does not even find its mark can, under certain circumstances, hurt more than one that finds its mark"
> (1984 p22)

It was this theme which for me seemed to encapsulate the others and was my wake up call. In my previous research I had acknowledged an inability to allow 'myself' to feel at any real depth (Burdess 2000). Such emotions as guilt, shame, fear, hate and a sense of wanting revenge were so apparent in 'my' personalities. What I was now discovering was, that in not being able to encounter these in my own right, I was locked in my own kind of prison, not experiencing the joys and the sorrows or the highs and the lows of life in 'my' own right. In one sense it was safe but in another 'I' was not free. It seems that the job of 'my' personalities was very much to experience the emotions that 'I' could not. The level of feeling that they can display was quite a revelation and 'I' began to be quite envious of them at times and at other times was grateful they were doing it for 'me'; quite a paradox. It seems that shutting off from emotions is a survival technique commonly used by sufferers of abuse and can be compared to the experiences of inmates in the concentration camps and prisons.

> "Apathy, the blunting of the emotions and the feeling that one could not care any more were the symptoms arising during the second stage of the prisoner's psychological reactions, and which eventually made him insensitive to daily and hourly beatings. By means of this insensibility the prisoner soon surrounded himself with a very necessary protective shell. (Frankl V 1987 p21)

The task of therapy was and still is to unravel the belief that is so entrenched that 'I' do not have the right to 'my' feelings and expression of them and also to believe that it will be safe to do so.

There were several factors which emerged leading me to acknowledge a sense of emotional imprisonment. (see table 3) Each of the factors could be qualified or explained by examples of incidents that illustrated these factors, such as fear of disclosure being brought about by the thought of reprisals or consequences. The very fact that the abuse was meted out in secrecy and to me on my own led to a sense of isolation and therefore segregation from both my peers and other adults. There was no-one to share feelings with.

Sense of imprisonment Present in	Examples	Ultimate effects
1. Isolation	Secrecy of abuse Hiding away Burying feelings Dissociation Inability to feel in "own" right	Fear Dissociation
2. Fear of disclosure	Reprisals Consequences Fear of being disbelieved Being different Rejection Judgement	Fear Hyper-vigilance Dissociation
3. Language used towards 'me'	Effect on behaviour patterns Effect on belief about "self"	Shame Dissociation
4. Sense of helplessness	Lack of skills Lack of options Sense of altruism Internalisation of blame	Vulnerability Fear Dissociation
5 Denial of emotions	Of rights Of feelings	Dissociation
6. Shame	Pervasive – felt everywhere	Dissociation

Table 3. Basis for theme of: sense of emotional imprisonment

5.2.1 Fear of Disclosure and Isolation

One of the reasons for emotions being denied was that any display of feelings or expression of opinion was often met with quite dire consequences leading to secrecy and a fear of disclosure. (see table 3) I have chosen to put these together here as the more I look at the data the more closely I can see a link between them.

In one session we were discussing the case reported in the newspapers of a young Caribbean girl, Victoria Climbie, who had been killed by her aunt and her boyfriend and this triggered memories of my own experiences at that age and led to evidence of how 'I' withheld emotion and how an alter would come into being to take over when things became too difficult for 'me' to handle. It also illustrates the sense of isolation and the need to deny and bury feelings in order to survive an ordeal. The alter who comes into the arena indicates the level of fear around and the possible consequences of revealing what is going on.

A. …and …um...the child's mother sent her over to England because she thought she would have a better…um…a better life over here and they think that the aunt has brought other children over via the Continent…I'm not sure but the police are investigating that….but her words…hau…haunt me…(voice still trembling)…she said "No matter how hard we beat her she never cried"….(silence)….um….
K. …and you know that feeling!
A. Ohhh!! (Tape 24).

The conversation continues and I begin to relate further my own experiences along side those of this Caribbean child.

A. Mmmm…..She didn't have anyone to lean on…She didn't have anyone to speak to…She stopped talking…Apparently the week before she died she just completely stopped talking…(said with emotion)…… (silence)….

K. Now I can't begin to imagine….other than ….what I've heard with you….I can't even begin to imagine the trauma of that child. Now you can…and I can in respect of you….you know what I'm saying…..Can you identify with stopping talking?
A. Oh yes!...(said with conviction)
K. Yes….(silence)….Why would she do that?
A. What's the point?....There's nobody to hear her. (Tape 24)

A little further on I start to tell **K** of an incident when I was 7yrs old. It is a classic example of dissociating when something becomes too painful. I admit to having times when I would stop talking for long periods.

K. What does it conjure up for you A?
A. I used to stop talking for long periods. (Tape 24)

Gradually the story becomes more difficult to tell, my voice becomes fearful and then I lapse into long silences reverting to type which **K** picks up on sensitively. The story is of a time I was made to stand in the corner of the hall for two days because I did not say thank you for my tea. (It was just one of many similar incidents) Experience has taught me with **K** that it is OK to tell the story and that it will be received with belief and sensitivity, yet I was full of dread and could feel myself remembering what I was told would happen to me if I ever told anyone. In the long silences here I was almost transported back to the scene and my mouth had gone dry and my heart was racing. **K** gently asks questions which I am unable to answer. A sense of fear here, in telling who was responsible, prevents me from answering his questions. Even though the person responsible is now dead I have this innate fear that they will be able to exact their revenge from the grave. It is the fear of the child in me. **K** continues to ask questions but I am totally unable to answer. I have reverted to type and have stopped talking. I am beginning to feel like that small child again and feel very vulnerable and disconnected with what I had revealed. I never told anyone as a child because I

thought it was my entire fault and that no one would believe me. I also thought that no one would give me the time of day so what was the point of talking? **K** is aware of what's happening and lets me know it's OK.

K. You stood there for two days?...Did you say you stood there for two days?...(long silence)….Did you not go to bed?....(silence)…..Were you fed?....(silence)…A?.....No?... Did your mother do that to you?....(long silence)….I'm aware you're not talking to me….(voice very gentle…silence)….You said you didn't talk because you had no-one to listen and I'm listening….(silence)….and I've been listening for a long time now….(silence)…..I'm sorry that happened to you….(silence)…I just find it…I said I believe….I just find it ….it's incredible ….just the notion of two days standing there…(silence)….

(Tape 24.)

Going over this tape was, I remember, particularly painful and I made several notes and observations especially around this section, which raised questions.

"My voice has become fearful. I am aware of the terror that I was feeling in the session, which I view as a safe place. I also remember the sense of hyper-vigilance I felt at this point brought on by the fear that I would be found out having told someone. (It needs to be pointed out here that what I reveal to K I have never revealed to anyone before.) The fear engendered in me as a child as to what would happen if I ever told anyone reached into adulthood to the point that it would be better for me to die than to expose the truth. This fear often precipitates dissociation. In dissociating it is not 'I' that does the informing. Revisiting this now and writing about it as an academic study is weird. I am trying to disengage myself from the experience and divorce myself from the whole incident. I am trying to step outside it and view it as a bystander, almost clinically. Is this to protect me? Am I reverting to type? Am I acting as an observer in a triad with K as the counsellor, A as the client and 'me' as the observer? Am I trying to do this clinically in an attempt to avoid dissociating? If so, does this defeat the object of the exercise, which is to gain an understanding of the feelings connected with dissociation? In a way I'm doing what I did as a child – dissociating, denying that the child now in question was 'me'. This was my way of handling terrifying or painful situations – by stepping outside them and observing

from afar. My fear here, now is that I will dissociate in writing this if it taps into feelings, which 'I 'can't handle. I don't like this sensation. Perhaps this is where I need to take a break.
(Diaried thoughts 21/1/01)

Shortly after this **Susie** makes an appearance. The incident is provoking too much for `me` to handle. She continues telling the story in some detail which `I` cannot recall and **K** is gentle and accepting. She explains that she stops talking because there is nothing to say and **K** gently probes further.

K. There's nothing to say….yet Susie…I'm…I'm aware that you talk to me….Mmm?....Is that because you have something to say to me?
S. Because you listen.
K. I do listen….so it sounds like you had something to say to someone who would listen to you.
(Tape 24)

Susie goes on to tell **K** what would happen if she expressed what she felt.

S. I used to…if I say….I get hit.
(Tape 24)

Looking at this now I can see how **Susie** retreated into her silent world. If she expressed any emotion or voiced any thoughts or opinions it was met with abuse. It was better not to respond at all. It was clear she was not to be allowed to have any form of expression so she hid within herself. It seems as though she metaphorically placed herself behind bars and fear was the key that locked her in. There was no-one to talk to and if there was would they blame her? Would they then dislike her and turn her away?

Much of 'my' emotional experience has been done by my alter personalities particularly during the abuse. It would appear that I was not allowed to express any feelings at all. They have often spoken of not being able to cry or to respond to pain.

Emily has difficulty with communication and often talks in monosyllables or short phrases and **K** has the task of gently teasing out what she is trying to communicate. (see table 1) This is where listening to the tapes is far more revealing than just reading the transcripts. So much is lost in the transcribing in the voice intonation and nuances and the unsaid implications – and most of all in the felt sense of the relationship between **K** and the alters and **K** and 'myself'.

Here **Emily** is trying to tell **K** about a particularly painful experience. It has taken her years to reach this point where she feels able to communicate with him and trust him enough to tell her story.

K. Is he hurting you now?
E. Mmm.
K. Is he?....What would you like to do E?
E. Screaming in my head.
K. Excuse me?....Emily I can't hear you darling.
E. Scream…in my head.
K. Sweetheart will you say that to me again. I'm sorry I'm not hearing you very well…could you say that to me again?
E. Scr…eam
K. Screaming in your head?
E. Mmm.
K. Would you like to do that out loud?.....No?...Why…Why not Emily?.....
E. Scream in my head.
K. You're screaming in your head…No noise…..No noise…nobody can hear you screaming in your head…Mmm….Are you screaming?
E. Noise.
K. Excuse me?
E. Mustn't noise.
K. You mustn't make any noise? …Are you screaming loudly in your head Emily?...It almost sounds like it wants to come out….Mmm?...Sounds like the scream

wants to come out Emily?....Does that scream want to come out Emily? ...Would you like to be able to scream?
(Tape15)

This section of the tape feels charged with unexpressed emotion both from **Emily** and from **K**. Very often the tone of his voice gives a hint of the emotions he is feeling but he judges that his expression of them would hinder the process at that time. I also know, listening to the tapes, when he has been reduced to tears and tries to hide it. He blows his nose! This passage sums up for me the sense that I have got through listening to many of the tapes, of the pent up and imprisoned feelings. On several occasions the alters have talked of screaming or crying in their heads. `I` have a very high pain threshold which I suspect I have developed as a result of both not being allowed to express pain and the response I received if I did.

K has often said that he feels that **Emily** is the most frightened and damaged of the alters and I think he is right. He gently encourages her to let go of her emotions whenever he gets the opportunity. Tape 28 is a particularly emotionally charged and difficult tape to listen to. **Emily**, who only presents herself through **Susie**, makes an appearance. Listening to the tape 'I' get a real sense of **Emily**'s loneliness and her voice projects a sense of helplessness and fear. **Emily** does much of her story telling through the use of buttons as her story is particularly agonizing. She shows how hard it was to cry and how she/'I' had devised a way of releasing some emotion inwardly.

This tape follows a session where **K** has a conversation with **Susie**, who is fiercely protective of **Emily**, telling her that it is OK to cry and if she or **Emily** wishes to do so in the safety of his room then they may do so. In this session **Susie** appears saying that **Emily** is close to crying and wants to come out. She makes her appearance behind a

large plant in the room and has to be coaxed out. Her first thought on appearance is for her buttons. It's as if she feels safe with them at her disposal. The conversation also continues from the previous session where they had been discussing the ability to cry.

E. Where are my buttons?

K. Your buttons are behind the chair….Emily …can I just stop you for a moment?...You were saying to me that it hurts in there…and you cry in here…you cry inside…When you cry inside Emily where do the tears go?....Inside?....Uh huh…down your throat…I understand…(Emily is here using signs to explain)….You can cry on the outside here if you'd like to… and that's all right…seriously…That's all right you won't get into trouble… (Tape 28)

Emily looks for her buttons but begins to get distressed as she cannot find them in the tin they are normally kept in. **K** recognises this and she refuses to cry. She throws the tin of buttons across the floor.

K. Are you sure they are not there Emily?.....Emily listen to me …other people use these buttons as well and they might have put some buttons in that weren't there and taken some out…I'm sorry if that's happened…..I'm sorry about that….You're really upset?...Are you really angry Emily?…What do you want to do?
E. I won't cry.
K. You can cry if you want to sweetheart.
E. I won't cry.
K. You can cry if you want to. You're welcome to cry here.
E. It doesn't pay to cry…that's what they said.
K. Uh huh…who said?
E. S.
K. I'm…I'm not S…I'm K…and if you want to cry here you have my permission.
E. You die if you cry.
K. You won't die here if you cry darling…no…I promise you, you won't.
E. You will.
K. Well I hear you saying that…
E. They say I'll die.
K. All I'm saying is that you won't die in my place if you cry…and this is my place….

(Tape 28)

A little later **K** remembers that he has put **Emily**'s buttons in a safe place and goes out of the room to get them. She is afraid that he won't come back. When he re renters the room **Emily** is crying quite audibly. What follows is quite emotional for both **K** and **Emily** and also for 'me' on listening to the tape.

K. I'm coming back…I'm coming back…(K leaves the room….long silence…sounds of crying noises from Emily,....K re-enter the room)….It's me…it's me…Problem solved miss! Look I had them specially in a ….in an envelope for you…(Emily crying)…because I didn't want any of my friends using them…Look at them sealed up with cello tape….and I'd forgotten…(takes buttons out of envelope)…I'm sorry about that…and eeeh…you're crying…you're crying real tears…Would you like a tissue to dry your tears?...A soft tissue?....Behind you…go on…dead soft. Touch it…see how soft it is…Shall I show you how soft it is?.... Now just touch it on your face and see how soft it is….There's….dry your tears….Look…there's real tears on there!...Real tears…and you haven't died have you?....You look alive to me….Real tears coming out the front…Mmm?...Look at them…Are they real tears…Mmm?...Emily, are they real tears?...Coming out the front?...Can you feel them/…and you haven't died have you?...I think I need one of those tissues because I've got some real tears as well….look….I've got real tears…(both crying)…You're even smiling…smiling and crying at the same time…Didn't believe you could do that did you?...Not bad eh?...Look at those tears…they're real ones there…Didn't know men cried did you?
E. Why are you crying?
K. Oh ..because I get upset sometimes…when I see little people hurting like you I get upset….yeah…I get upset and cry just like you…hey Emily you've cried…and the tears have come out of the front and you're alive…so when S says if you cry you'll die, he's wrong!....look there's two of us who've cried and your not dead and I've cried and I'm not dead. (Tape 28)

I learned from a very young age never to let anyone see I was hurting. I learned to cry inside. Tears would go down the back of my throat and not down my face. **K** has taught 'me' through Emily and the other alters that it is OK to cry and to express feelings and nothing untoward will happen.

Helen is the character who is most at ease in telling **K** what happened and she and **Emily** are the ones from whom I have learned most of why 'my' emotions are so restrained.

Helen is here telling **K** of an incident and also fearfully of what will happen to her if she does tell.

K. What might happen?
H. You mustn't!
K. What'll happen to you.
H. I'll die.
K. You'll die?...uh huh….Let me tell you, if you say in this room you won`t die….Has anything…has anything ever happened to you in this room?....Has anything bad ever happened to you in this room?...Mmm?
H. No.
K. No…and nothing will either….
H. If I tell anyone I will die!
K. So does that mean you're not going to tell me anything?....but…you have told me things haven't you?....(distressed breathing from H)…and you haven`t died. have you?
H. They'll come and get me.
K. They haven't come to get you …have they Helen?
H. They will!....They said if I told anybody I'd die….(whispered)….
K. Right….right…well I promise you…. (Tape 94)

To be threatened with death is enough to make any child hide everything (see table 3)

Later in the same session **Helen** talks very matter-of-factly about the time her teddy bear was taken off her. She reveals that she is not expected to express her feelings and if she does there are consequences.

H. I'm not allowed to get angry.
K. You're not allowed to get angry….Who said that?
H. I'm not allowed to cry.
K. You're not allowed to cry (Tape20)

A little later she elaborates on this

H. If I get angry they`ll get the belt out.
K. Uh huh…If you get angry who`ll get the belt out?

H. S.
K. S'll get the belt out if you get angry?
H. If I get angry then Leah comes out and she gets us into trouble. (Tape 20)

A. I hate them. I don't want my teddy on the fire…I hate you!
K. Who do you hate?
H. I hate you.
K. Who do you hate Helen?
H. I'm not allowed to hate.
K. But you're saying…I hear you saying that you hate somebody. Who do you hate?
H. S.
K. So you hate S….Can you say a little louder that you hate S...Mmm?
H. No. I'll make Leah angry…..if she gets angry we get into trouble. (Tape 20.)

K is very aware that 'I' have great difficulty in allowing myself to express 'my' feelings so whenever one of the alters shows any sign of emotion he actively encourages them as seen with **Helen** above. I recently revealed in a session that I remembered the last time 'I' cried. I was about four or five years old sitting in a field. 'I' never cried after that. If 'I' come near to crying in a session 'I' always manage to stave it off.

A. If I feel as though I'm going to cry I always block myself.
K. I know you do A. (Tape 112)

5.2.2. Discussion.

> "Everyone has the right to tell the truth about her life. Although most survivors have been taught to keep their abuse a secret, this silence has been in the best interests of the abusers, not the survivors."
>
> (Bass and Davis 1998 p133)

As a child the fear of disclosing what was happening to me was so great that it was never really an option. There was the added fear of not being believed. Who would take the word of a child against an adult? I was also abused during an age when abuse

was not really recognised or certainly acknowledged or talked about and if by chance it did happen it did not take place in 'good Catholic homes'. There was only one occasion when I tried to disclose and that was in the confessional. As a Catholic it was a duty performed almost on a weekly basis, to go to confession to rid oneself of the sins committed during that week. When I reported what was happening I was told how wrong it was to make such terrible accusations and was sent away without the absolution that, as a Catholic child, I desired. I never disclosed again. If the priest would not believe, and he stood in for God, then what chance was there that anyone else would believe? I felt abandoned and isolated by the Church. I also felt dwarfed by its power.

"The counsellor's initial response to the client's disclosure of childhood sexual abuse is extremely important. Disclosure, if not handled skilfully…can have deleterious effects. If survivors perceive the counsellor's response to disclosure to be non supportive, they may leave counselling, resist further discussion of the abuse issue, or minimise the impact of their abuse experience."

(Draucker 1992 p29)

Telling **K** about my abuse was hard but once I had told him that it had happened it was if I was compelled to discover the full truth of my story. I needed to be heard and to tell it in its entirety. He received the horrors with compassion and a desire to understand and help. It took a long time to trust him and realise that he would not betray this trust. There were never any threats from him which as a child had been part of my daily diet. Threats of being abandoned or ostracised, of physical punishment and even death were an intrinsical part of the abuse and all served to maintain the secrecy and the sense of isolation I felt. The alters often talk of their fear of reprisals should they speak out

K. What'll happen to you?

H. I`ll die.
K. You`ll die?...Uh huh....Let me tell you, if you say in this room you won`t die.....
H. If I tell anyone I will die.....they'll come and get me.....they will!.....They said if I told anybody I'd die....(whispered)....
(Tape 20)

I can concur with Herman (1994) who states that childhood abuse takes place in a "familial climate of pervasive terror" (p98) and that in her experience survivors describe a

"characteristic pattern of totalitarian control, enforced by means of violence and death threats, capricious enforcement of petty rules, intermittent rewards and destruction of all competing relationships through isolation, secrecy and betrayal."
(p98)

Susie reported in one session how her teddy bear was taken off her and thrown onto a fire during one episode of abuse. She also related her fear that her pet dog who had disappeared may have met the same fate.

S. They took my dog.
K. They took your dog...I think I would hate her as well...(silence)...
S. They wouldn't have put him on the fire like they did my teddy would they?
(Tape 24)

Herman (1994) recounts how violence or murder threats may also be directed against other family members or pets as a way of ensuring silence.

Herman (1994) also notes that the abused child is often isolated from other family members as well as from the wider social world. It seems according to Herman that the abused child perceives that not only is the most powerful adult in her intimate world dangerous to her but also that other adults who are responsible for her care do

not protect her and in deed, as in my case, are also sometimes actively complicit. If there is no-one to turn to or trust then the child resorts to other measures to fill this void. I spent much of my time shut away in my bedroom becoming involved in the fantasy of the story books.

Disclosure of DID often comes about after sometime in therapy. It is not something that is usually divulged by the client or discovered early on in therapy. Mollon (2002) says that

> "It is not uncommon to hear of instances where a psychotherapist takes on a patient who seems only moderately troubled, only to discover months or even years later that a severe dissociative structure has become manifest……"
>
> (p189)

It was three years before I disclosed to **K** what was happening. I had gone to great lengths to hide my dissociation both as a child and as an adult and I was not about to reveal this side of me to anyone I didn't trust. Spanos (1994) supports the assumption that DID individuals are attention seeking and obvious in their display of symptoms. I agree with Armstrong and Loewenstein (1990) who found DID clients to be intellectual, introspective and obsessive about their privacy.

It appears too, that there is an assumption among some researchers that if sexual abuse is kept secret and not disclosed until adulthood, that there will be a greater degree of mental health impairment. Bagley and Ramsey (1985) found a rather fragile association here which disappeared when other factors were taken into consideration. Finkelhor (1979) found no relationship and Tufts (1984) found that children who took a long time to disclose showed the least anxiety and hostility. My leaning is towards the findings of Finkelhor and Tufts. I would not class myself as having a high degree

of mental health problems. I have held and maintained (and still do) exacting careers and have married and raised a family without having to resort to the mental health system other than to come into counselling. However I am aware that some DID sufferers have been in the mental health system for years, often having been misdiagnosed. Other factors will influence how people respond to disclosure. If a child discloses to a parent who is angry and punitive then more trauma may be generated. Anderson et al (1981) found that symptoms were two and a half times worse if the parental response was negative suggesting that negative responses aggravate trauma but that positive responses do not necessarily ameliorate trauma. When I came out of the confessional having been met with condemnation, albeit not parental, I retreated further into my world of silence. It had the affect of re-traumatising me, confirming my belief that I was to blame – and I was on my own.

The inability to tell because of the fears surrounding disclosure led to isolation and manifested itself in a degree of depression which was what first brought me into therapy. Looking back I suspect that I was suffering from some depression as a child and during adolescence but this was controlled by my ability to dissociate. It was never to my knowledge noticed by family or teachers which was possibly to my detriment. I was just classed as a quiet child.

In the clinical literature, depression is the symptom most commonly reported among adults molested as children and empirical findings seem to confirm this. Bagley and Ramsey (1985) found that subjects with a history of child sexual abuse scored more depressed on the Centre for Environmental Studies Depression Scale (CES-D) than did non abused women (17% vs 9% with clinical symptoms of depression in the last

week). In 1985 Brier and Runtz using 72 items of the Hopkins Symptom Checklist did a controlled survey of 278 undergraduate women which indicated that sexual abuse victims reported that they experienced more depressive symptoms during the 12 months prior to the study than did non abused subjects. It would be interesting to measure this with subjects who have dissociated as a direct result of abuse. However I could find no such research. Could the ability to dissociate dissipate the propensity to depression in subjects who were sexually abused? Could the ability to dissociate dissipate the propensity to depression again in those unable to disclose?

In an extensive study of 153 "walk ins" to a community health centre, Briere and Runtz (1985) reported that 51% of the sexual abuse victims, versus 34% of nonabused clients, had a history of suicide attempts. I made three attempts at suicide up until the age of 26yrs, my first around the age of five years (see Ch1). However I am sure that my ability to dissociate protected my psyche and enabled me to function at an acceptable level and 'hide' the depression from the outside world. There were times when what was happening became utterly intolerable and a sense of hope disappeared. Those were the times I think I resorted to attempts at suicide; not very successfully as you can see. Perhaps failure in the attempt of suicide led me to perfect or fine hone the art of dissociation.

Fear of disclosure is how I have labelled this category; fear being the operative word. Throughout the tapes there is a sense of fear so evident it is almost tangible. 'I' and the alters often talk of fear and 'my' and their voices are often display that emotion. **K** has on several occasions said that for him the thing that comes across so forcibly is the level of fear/terror they (the perpetrators) engendered in me. I have a high level of

hyper vigilance and alertness. The alters often check with **K** that he will not repeat what he is being told by them. Browne and Finkelhor (1986) in their review of research on the impact of child sexual abuse note that

> "Breaking down emotional impact into specific reactions, we find that the most common initial effect noted in empirical studies, similar to reports in the clinical literature, is that of fear."
>
> (p2)

It seems to govern most of 'my' thinking and feeling and is the key to dissociation. It is therefore one of the keys to 'my' sense of emotional imprisonment. Fear stops. It is the master of prevention. Fear of disclosure and the consequences of that disclosure prevent that disclosure. I am therefore not surprised by the finding of Browne and Finkelhor (1986).

5.2.3. Summary

It seems that there are many factors which contribute to fear of disclosure. Living with threats of reprisals and the consequences of disclosure have a huge impact on the decision I made not to reveal what was happening. The fear of being disbelieved or being judged it seemed reinforced the decision against any disclosure and this together with a perceived rejection sealed the decision not to tell. Although this is the evidence of one case further research using larger sample groups may provide more consistent results enabling a more precise isolation of which factors account for differential effects and severity of trauma in survivors.

5.3. LANGUAGE USED TOWARDS SELF

I found too that words have a power to imprison. They can have profound effects on behaviour and on the perceived sense of self. Another session sees **K** and me talking about a previous session when Susie had told him how she was often called "ugly".

A. It probably sounds really very trivial in comparison to….but there was one word on that tape….(silence)….um…it reminded me so….(silence)..It's amazing what one word can do.
K. Mmm….(silence)….and the word?
A. It was a word that made me suffer so much as a child……I'd forgotten really just how ….how much that used to penetrate…(silence)…They used to say it so often.
K. Who used to say it so often?
A. My mother….oh…they all used to at some stage or another.
K. The abusers?....Right.
A. You can actually feel it….(silence)…When I listened to the tape it just seemed to….it seemed to jump out at me….(silence)….
K. (gently)…and the word?....(long silence)….
A. Ugly.

K. Ugly…Mmmm. They called you that many times didn't they?....Does it still have …power for want of a better word, to traumatise you?
A. Yeah….(squirming with embarrassment)…
K. Mmm….(silence)…Sounds like it has great power to imprison you….lock you away …one way or another…Who calls you ugly now?...(silence)…You didn't answer me…You don't have to obviously….(long silence)…does N call you ugly…..Mmm…From one abusive situation to another. (Tape 34.)

The discussion led to further revelations of times when I was called ugly. Here I was describing how one of my abusers saw me

A. Yes…and um….he never really sort of said very much and then…just looked up and said "You're right she is an ugly little witch…and um…I just felt as if the room was crowding in.
(Tape 34.)

I also recalled an incident when I was at Junior School. I had been given the lead part in a school play and was so proud. I was to be a character called Jaffa, an Arab prince. I was dressed in green pyjamas and wore a gold turban and had my face and hands blackened out. After the performance comments were made by various people.

A. I was standing there as pleased as punch because it had been received very well.
K. Uh huh…. still with your blacked out face?
A. Yeah…My uncle was looking at V and looking at me and saying "Well you can tell why she got the part…um…they couldn't give her anything else. At least they could hide her face.
K. What an outrageous thing to say!
A. I remember….I just…everything in me just….
K. …died.
A. …because I thought I got the part because I was good…(silence)….
K. God they cut you to pieces didn't they?...Without even laying a finger on you.

(Tape 34)

It is amazing the links that children will then make when something like this is fed to them. Language, and interpretation of language, can have lasting effects and contribute to perceptions and beliefs about self and situations (see table 3) I was adopted as a child and I spent many years with thoughts that were so wrong.

A. I mean I used to think that was one of the reasons why my mother ….my real mother gave me away…because I thought she was ashamed of me…I thought she'd think I was so ugly.
K. You've got some pictures of you as a child haven't you I think maybe we need to have another look…to remind ourselves that you were far from ugly…to remind you…I…I'm in no doubt…seriously. Maybe we need to have another look to prove what I say that you were a canny kid…and if they hadn't damaged you so much you would have grown up with a different image.

(Tape 34)

And also

A. I used to…I used to ask God to make it all stop and of course it never did…and I used to plead with him to make me pretty and of course he never did…so I stopped asking…(silence)….and then I remember being taught at school that beauty came from within…I remember one of the nuns saying that….and I thought I must be ugly from within as well.
K. Mmm…because they were calling you ugly on the outside therefore you must be ugly from the inside. Do you regard yourself as ugly now?
A. Mmm….(embarrassed…..silence)

(Tape34)

These concepts which were born in childhood matured in adulthood and have affected the way I behave pushing me further into an emotional prison. Here I am talking about a couple of incidents with an old friend J. one where we were shopping and another when we were on holiday.

A. I used to spend her money you know…on her…..but I used to dread…sometimes I used to dread going shopping with her because she used to say "Why don't you try that on? Why don't you buy something for yourself?....because I would always end up taking things home for the children…(laughing)…Why don't you buy something for you….but I wouldn't go into the changing room. Sounds stupid doesn't it?
K. You wouldn't go into the changing room because?
A. I wouldn't try anything on in front of anyone else…(embarrassed)…I have no illusions!!
K. Excuse me?
A. I'm under no illusions.
K. Under no illusions of what?
A. …(very quietly)…I didn't want to show myself in public……(silence)…
K. So you believed….no, believe what they say …lets put it in the present tense.
A. Oh yeah….(silence)…and if you remember J and I went on holiday. She took W and I took K….The kids used to laugh because I wouldn't wear a swim suit…..(silence)…
K. What's the ongoing effect now A…the ongoing effect of them convincing you that you were ugly?....You know…you wouldn't put on a swim suit…I mean it happened a few years ago now but what's the ongoing effect?
A. Well they were right…..I hate having my photo taken…I remember the sense of shame when I was little ….and that sticks….this sense of shame that it was my own fault that I was ugly.
K. Do you regard yourself as ugly now?
A. Mmm….(embarrassed)….(silence)…….I look in the mirror and I hate what I see.
(Tape 34)

It was not until I listened to these tapes that I have realised how badly I have been affected by what I was told as a child and how this has seriously stunted my emotional development. Believing what I was told so often led me to restricting myself of many of life's experiences. I did not feel free to go out and taste life in its entirety or at least perhaps within my own personal limits and ability. I never knew what these were.

Over the years throughout therapy 'I' have often described a very lonely child, one who hid away in her room escaping into books, one who was very often kept from playing with other children and one who took great pains to build an edifice to present to the outside world that everything was fine. This added to the sense of segregation, of not being good enough, of being different to others, of isolation and imprisonment. (see table 3) So often this would spill out into life even now.

In this next section this is highlighted well. I had been describing an incident that had happened at work and how it had disabled me and triggered old sensations. It shows too how the effects of the past can affect current behaviour

A. It is such an effort to go out….but I know that if I don't…if I stop going out that would be it….
A. I was imagining all sorts…
K. Yeah….whilst you were sat there…. all sorts of things were going through your mind.
A. You know and I…..It's almost as if I'm waiting for it (the abuse) to happen again.
K. Uh huh…..and are you?....
A. I'm frightened that it will.
K. Uh huh….What do you need to do…two things A….What do you need to do …a) in order to prevent it happening again…and b) what you need to do so that if it does happen again you can respond in a away that prevents you getting hurt?....(silence)…
A. My temptation in answer to the second question is not to go out….That is so real. It would be so easy.
K. …to stay indoors?
K. Right…if you stop going out A what could the consequences of that be?
A. Everything would grind to a halt….it would just…everything I ever worked for would just… (silence)….I mean there is that side to me that fights and says "No…I won't let that happen"….but it just seems to bring back…
K. A…what is it in you that actually fights against not going out….that actually fights to keep the show on the road as it were?
A. This fear of failure I think….The one thing I know I've inherited from my mother is the need to make everything look OK.
K. Mmm….to keep the show on the road….to keep the edifice in position….keep everything moving.
A. I've always done that from being so small….I've hidden everything…of anything that was going on…anything that happens…my instinct is to hide the evidence.

(Tape 32)

The conversation continued and triggered memories of an incident in childhood.

A. I remember C and I went back out the front…and I sat on the steps while the others played…and my mother was in the back garden…
K. Mmm….You sat on the steps because of the pain in your knees?
A. …and the feeling of being alone is probably one of the sharpest memories I have of feelings.
K. Mmm….yeah… (Tape 32)

In turn this brought that feeling into the present.

A. …and then I think…that's when I think it would be so easy to shut the front door…. And then there's that bit of me that knows that if I do that….then everything that I've worked for will just collapse ….and suddenly I feel dreadfully alone again
K. Mmm…so part of you that could close the front door….and another part of you A that …I may be wrong here…it seems to me…another part of you that values some of what you've got and what you've worked hard for and what you've achieved…and doesn't actually want to….
A. I don't want to let go.
K. ..and what makes you not want to let go?.....(silence)…
A. The bit that I hang on to that one day I can turn round and just say …you didn't win.
K. Uh huh…So still a desire to fight the battle?
A. Yes…but it's getting harder and harder. (Tape 32.)

It seems to me now, studying that tape that the old defence mechanism of hiding or holding in what 'I' am feeling (see table 1) in order to protect does not always necessarily work. Hiding what you are feeling can in fact do the opposite and leave you vulnerable and isolated.

5.3.1. Discussion

"If a child lives with criticism, He learns to condemn.
If a child lives with hostility, He learns to fight.
If a child lives with ridicule, He learns to be shy.
If a child lives with shame. He learns to feel guilty.
If a child lives with tolerance, He learns to be patient.
If a child lives with encouragement, He learns confidence.
If a child lives with praise. He learns to appreciate.
If a child lives with fairness. He learns justice.
If a child lives with security. He learns to have faith.
If a child lives with approval. He learns to like himself.
If a child lives with acceptance and fairness. He learns to find love in the world."
(Dorothy Law Nolte)

According to the Collins Dictionary language is a system for the expression of thoughts, feelings etc by the use of spoken sounds or conventional symbols.

Thinking and language become more complex and sophisticated, although a child's understanding of language usually exceeds its ability to use it. A child may also use a word correctly before it grasps the underlying concept. As adults, thinking often goes on through different mediums such as imagery and we often express our thoughts through gestures, body language and facial expressions.

Lev Vygotsky (1962) developed ideas in cognitive development particularly the relationship between language and thinking. He argued that language was the most important symbolic tool provided by society. He viewed thought and language as originally quite separate activities which come together and interact at a certain point of development (about 2years old).

A second view, as represented by Piaget, takes the view that language is dependent on, and reflects, the level of cognitive development.

Bruner's (1983) theory of modes of representation or different forms which our knowledge can take sees language as being essential if thought or knowledge is not to be limited to what can be learned through actions or images.

Watson (1924) noted the role of environmental influences on the individual almost to the exclusion of any 'internal' psychological factors therefore language is the greater

influence because it is public and can be studied objectively in its spoken form. while thought is too inaccessible to others to be considered worthy of scientific investigation.

As an adult I am aware that I not only listen to what someone is saying but I am intent on watching body language and facial expressions. I look for anomalies here, as well as taking in the nuances and silences of conversations. I listen to voice tones and inflections and take all of these into account before judging the sincerity, reliability and importance of a conversation. I am confident this came about through my need as a child to be hyper vigilant and aware in my world. I always felt the need to be one step ahead of my abusers. My experience runs here with Bruner (1983). My need to develop language as a way of competing in my adult world of severe and dangerous actions and images was vital for my protection even though sometimes my use of language was seen as subversive and brought reprisals.

I think I recognised this need to develop language from an early age as it also provided a means of escape. I learned to read from a very early age. By the age of four I could read fairly simple books making connections with words and pictures. By the age of eight I was reading fairly advanced books having worked my way through the children's section of the local library. Poor reading skills and their relation to conduct disorder have been discussed by a number of writers, including Rutter and Yule (1976) and Pringle. Butler and Davie (1966) who concluded that "The incidence of maladjustment at the age of seven was four times higher among poor readers than among the rest of the cohort". (reference to a study made). It seems that my ability to read from a young age could have been contributory to my behaviour. There was,

however as I see it, a disadvantage to having a competence of language from an early age. I could understand fully what was being levied at me in their insults and put downs but did not have the life's experience to understand that there could be alternative viewpoints or opinions. What they said was true and their actions reinforced this. I had nothing at a young age with which to compare and disprove what was said. Hence I believed them. By the time I was old enough to understand that everyone is entitled to their own views, beliefs and opinions I had fully taken on board their verbal calumny and they had become 'my' beliefs, so much so that even the alters were affected. Language + actions = truth.

Chomsky (1965) developed a theory as regards the growth of a child's knowledge of her language which posses that we are innately equipped with knowledge about what human language is like, about the kind of system it is. He supposes us to be provided from birth with a special sensitivity to those features of the grammars of human language which are 'universal'. Hence he sees that we are able quickly to recognise or latch on to, the ways in which these features manifest themselves in the language. He maintained that children are born with a 'language acquisition device'. My ability to read and understand language from a very young age does bear this out to some extent but I feel there was more to this than just an innate knowledge.

Macnamara (1972) came up with a different view which seems to offer a more satisfactory explanation as to how I became to read and understand language from an unusually young age. He proposed that children are able to learn language precisely because they have a relatively well-developed capacity for making sense of certain types of situation involving direct and immediate human interaction. So it makes

sense to me that a child will form an understanding of a word when it is accompanied by a human interaction e.g. the word naughty delivered in a cross tone with a facial expression to match, followed by a smack will be more quickly understood and reinforced. This can therefore apply to reading. If a word or a phrase is accompanied by a picture illustration a child can quickly connect the two and make an understanding.

A. It was a word that made me suffer so much as a child……I'd forgotten really just how ….how much that used to penetrate…(silence)…They used to say it so often.
K. Who used to say it so often?
A. My mother….oh…they all used to at some stage or another.
K. The abusers?....Right.
A. You can actually feel it….(silence)…When I listened to the tape it just seemed to….it seemed to jump out at me….(silence)….
K. (gently)…and the word?....(long silence)….
A. Ugly.
K. Ugly…Mmmm. They called you that many times didn't they?....Does it still have …power for want of a better word, to traumatise you?
A. Yeah….(squirming with embarrassment)…
K. Mmm….(silence)…Sounds like it has great power to imprison you….lock you away …one way or another…Who calls you ugly now?...(silence)…You didn't answer me…You don't have to obviously….(long silence)…does N call you ugly…..Mmm…From one abusive situation to another. (Tape 34.)

The spoken word seems to put the seal of truth to actions and therefore is very powerful.

The old nursery rhyme is so untrue. "Sticks and stones may break my bones but names will never hurt me" as Frankel reports in his memories of his experiences in Auschwitz

"At such a moment it is not the physical pain which hurts the most…..it is the mental agony caused by the injustice, the unreasonableness of it all. Strangely enough, a blow which does not even find it's mark can, under certain circumstances, hurt more than one that finds its mark" (1987 p22)

My experience adds weight to Vygotsky's (1962) theory that, the meaning of a word represents such a close amalgam of thought and language that it is hard to tell whether it is a phenomenon of speech or a phenomenon of thought. A word without meaning is an empty sound; meaning, therefore, is a criterion of 'word', its indispensable component. It would seem, therefore, that it may be regarded as a phenomenon of speech. But from the viewpoint of psychology, the meaning of every word is a generalisation or a concept. Since generalisations and concepts are acts of thought (Vygotsky 1962), we may regard meaning as a phenomenon of thinking. However, it does not necessarily follow that meaning formally belongs in two different spheres of psychic life. Word meaning is a phenomenon of thought only in as far as thought is embodied in speech and speech only in as far as speech is connected with thought and illuminated by it. It is a phenomenon of verbal thought, or meaning of speech – a union of word and thought. The power of the word, it seems to me, lies in the thought behind it and delivered with enough imagery can convince and therefore shape a belief. The adjectives of life can be damning or invigorating and encouraging. Ridicule or criticise and we become condemnatory and shy. Tell a child she is ugly and she will hide or shy away. Tell a child she is pretty and clever and she will blossom and grow in confidence.

There were times as a child when language was inadequate to describe what was happening or how I felt as illustrated when talking in session 24 about the episode at the age of seven of standing for two days in the hall for not saying thank you for my tea. In the chaotic world of abuse, it is abuse itself that become the language. I can identify with Kafka in '*In the Penal Colony*' when he explains why the suffering inmate has not been told what his crime was "There would be no point in telling him.

he`ll learn it on his body" (1919/1948 p197). Language seems weak and powerless at times compared to the language of violence and threat of violence with its attendant disruptions. Sometimes a new language is needed which can contain a cathexis of bodily energy: this is the creative expression that can be forged out of emotional pain and the traumatic material to be worked through. Emily has found her own language through the use of buttons and becomes incredibly distressed if this is not available.

5.3.2 Summary

Language, and its interpretation, is an important medium of communication and its intentions can be reinforced with other methods of communication such as body language and voice inflection and tone. What language is used to us as children profoundly affects such areas as self-belief and confidence and our whole image of self. There are times when we need to find other methods of communication as Emily demonstrates. Simon shows, with his stutter, how experiences can disturb our verbal communication.

5.4. DENIAL OF EMOTIONS.

In not being allowed to express feelings or emotions as a child, in being denied this basic function, I gleaned that I did not have the right to them. This in turn reinforced that I was in fact different from others. It seems that in order to dissipate rising, forbidden emotions I learned to dissociate as both a defence and as a way of releasing these feelings; a practice that I inevitably took into adulthood. It is evident that when fear or pain and even joy are around an alter takes over as shown with the emergence of **Emily, Susie, Helen, Simon** and **Leah** in some sessions. Hence the emotions that were to be denied me in childhood by the perpetrators, I now deny myself.

Emily talks of "crying inside" and the tears going down the back of her throat

K. …Emily?.....can I just stop you for a moment?...You were saying to me that it hurts in there…and you cry in here….you cry inside….When you cry inside Emily where do the tears go?...Inside?...Uh huh…down your throat…I understand.
(Tape 28)

She also talks of 'screaming inside her head'.

E. Scr…..eam….
K. Screaming inside your head?
E. Mmm.
K. Would you like to do that out loud?....No?...Why…Why not Emily?
E. Scream in my head. (Tape 15)

Helen talks of not being allowed to be angry or to cry

H. I'm not allowed to get angry.
K. You're not allowed to get angry …Who said that?
H. I'm not allowed to cry. (Tape 20)

Helen also talks about not being allowed to hate and then actually is able to say it with conviction.

H. I hate them. I don't want my teddy on the fire…I hate you!
K. Who do you hate?
H. I hate you!
K. Who do you hate Helen?
K. I'm not allowed to hate (Tape 20)

Describing this here and transcribing the tapes does not give justice to or present effectively the emotion with which the conversation **Helen** and the other alters have with **K**. I have to reiterate here that the tone of voice, the nuances and the punctuated

silences cannot be reproduced on paper. The atmosphere of the sessions is lost to the reader through not being able to listen to the tapes. It is very poignant for me to hear how much emotion and expression of feelings 'I' have lost throughout the years and this gives me understanding of the sense of emotional imprisonment that I now feel.

The sense of not having the right to feelings or to expression of them (see table 1) can leave me very vulnerable at times and is something that needs great attention in therapy. 'I' have had many a hard session dealing with this issue and have had difficulty accepting that I can 'feel' in 'my' own right. It feels quite scary to allow 'me' to feel and I have difficulty in recalling 'feelings' as opposed to events. I suppose the question that springs to mind here is 'If I allow 'myself' to remember the emotions as well as the events would 'I' still survive or would it all be too much to handle, even now, when I realistically know I am safe?'

Even though 'I' now have memory of events 'I' do have difficulty with the recall of feelings as the following exert shows.

A. It feels as though there are different parts of me but …the me that 'I' know as me…is like everybody else…um….knows they have experienced things you know?
K. Knows that they have experienced pain but can't actually feel it?
A. Yes…and yet there are these other sides to me that when they are recalling their pain…
K. …it's real…it's there.
A. …it's not just an experience that they've….
K. ….It's not just an experience that they can't now recall. it's actually happening for them.
A. Yes…Does that make sense?
K. Yes it makes perfect sense.
A. …and the picture I see of all this is…or what 'I' can remember is of 'me' floating off somewhere….and then watching it all happening….and not feeling it. (put in illustration)
K. Watching it happen to them

A. …and the person that's 'me' I've made into someone else….so it's not 'me' it's happening to.
K. It's Emily or Simon or whoever.
A. Yes…and I have …'I' know when things start coming through…when I feel that something is coming through…it's as if 'I' remember that there has been some sort of pain…but 'I' can't recall…how it feels…..
K. …Well what I hear you saying is that when something is coming through you remember…the incident but you are not …and you know there is pain associated with it….but you are not able to recapture that pain or feel that pain…whereas they are.
A. That's it.
K. So when something's breaking through and is breaking through in the person of one of them (the alters)…they are able…they are reliving it as if it's happening now for them. Is that…
A. Yes…Does that make me mad?

(Tape 112)

5.4.1. Discussion

Denying someone the right to expression of their emotions is like denying someone the right to their senses. Like our senses our emotions are there for a reason. They are there to inform and to motivate.

> "Our feelings are the source of our energy: they provide the horsepower that makes it possible for us to accomplish the tasks of living."
>
> (Scott Peck. The Road Less Travelled. p156.)

As human beings we are very complex psychologically. We have minds that are able to reason, learn, remember and form concepts, opinions and ideas. We are able to activate ourselves towards goals and in there doing are motivated by reason and intelligence. However, we are also subject to desires, passions and other feelings which can also motivate these goals often in a direction different from that which reason dictates. These are the feelings we call emotions. The word emotion itself comes from the Latin word 'movere' which means to move – appropriate, as emotions normally serve to move us into doing things. However they are not the only source of

movement. We have the need to satisfy such basic survival requirements as food and clothing and this requires ration.

Emotions set the tone of our experience and give our lives vitality. My own experience suggests that without these emotions, without the highs and lows they bring, we are merely existing. It is our emotions that bring us to life. They are internal factors which give us energy and direct and sustain our behaviour usually initiated as a reaction to something outside us – circumstances in our environment. If that something outside us is intolerable the psyche develops ways to protect itself. Dissociation has been described as one of these ways – as both a defence and a coping mechanism (Putnam et al 1986: Ross 1999.) It is my experience that dissociation is also a way of dissipating feelings that cannot be expressed safely contributing to this sense of emotional imprisonment.

Many of 'my' personalities describe emotions that they feel that 'I' had never experienced for fear of reprisals. (see table1.) **Leah** is so definitely the voice of anger. **Helen** fearfully talks of "hating". **Emily** is the notable, vocal voice of terror. As a child 'I' learned that to express any kind of opinion or emotion brought reprisals. **Susie** and **Emily** both talk of developing the ability to "cry inside" physically to the point where tears would run down the back of their throats and not down their faces. It is quite a phenomenon for **Emily** when she sees her tears for the first time.

K. …I'm sorry about that…and eeeh…you're crying….you're crying real tears….look….there's real tears on there!.....Real tears coming out the front…..I need some of those tissues because I've got some real tears as well…I've got real tears….look at those tears…they're real ones……

(Tape 28)

Simon talks of hiding pain and screaming inside his head.

S. S..s…s…scream…you s…s…shut up…I have t…to…sh….shut up.
K. You have to shut up….so you mustn't scream. Is that what they are telling you?...Mmm?.....
S. S….scream in my head.
K. Screaming inside your head…yeah….OK….

(Tape109)

There are several acknowledged theories of emotion. The James-Lange Theory was one of the earliest and perhaps the most influential theory of emotions. This theory suggests that when we perceive a threatening stimulus near us, the perception immediately affects the autonomic nervous system. This creates a specific response with increases in blood pressure, heart rate and breathing. It assumes a different pattern of physiological response for each emotion – as the message is then sent to the brain about the type of response which is then assessed and we experience the relevant emotion. One of the main criticisms of this theory is that there is little difference between the physiological patterns of arousal in several of the emotions such as fear, anger, shame and sadness, yet our facial expression, body language and the way we ourselves rate the experience differ considerably.

In 1927 Walter Canon proposed another theory that examined how emotions worked. This was modified by Philip Bard and became known as the Canon-Bard Theory. While this one has some links with the James-Lange theory, the direction of the initial stimulus is different. This theory suggests that when a person is faced with an event that affects them, the message collected from the sensory system travels to the thalamus in the brain. Here the message is divided with one part going to the cortex where we have conscious subjective experience of the emotion such as fear, joy,

surprise or sadness. This is what we say when we are asked what we are "feeling". The other part goes to the hypothalamus which then triggers the physiological changes, facial expressions and body language that go with certain responses.

I have asked the question before how this fits with a dissociative response. My dissociation came about as a result of an external stimulus, namely abuse. The initial dissociative response came during an act of abuse but subsequent dissociation and the development of the personalities arose also from anticipation of abuse (box1) as well as the situation I would find myself in. The anticipation of abuse would bring about a sense of fear which began cognitively in the form of memory of a past, similar experience and knowledge of what was about to come. Almost immediately, simultaneously, this seemed to bring about physiological symptoms such as sweating, shaking and rapid breathing within seconds of the thought/memory. It is my experience that very often the physiological changes that I can experience are similar, if not the same, heralding different emotions. The feelings of fear, shame and anger all produce shaking, sweating, facial flushing and rapid heart rate and breathing before dissociation takes over. The personalities were conceived it seems, to take away these experiences from 'me' and to protect 'me' from the overwhelming emotions 'I' felt unable to cope with locking me inside myself. I am therefore inclined to concede to the Canon-Bard theory that emotional and physiological changes are set off simultaneously through the activation of the hypothalamus and that the James-Lange theory that each emotion heralds its own set of physiological symptoms falls short of my own experiences.

In the 17th century, Benedict de Spinoza described emotions as bodily changes that result in the amplification or attenuation of action and as processes that can facilitate or impede action. For Spinoza (2002) emotion also included the ideas or mental representations of the bodily changes in emotion.

There continues to be researchers who define emotions in many different ways. At the extremes, emotions can be seen as biological responses to situations over which we have little control. Plutchik`s theory of emotions is one that stems from the biological perspective. In many ways it can be seen more as a description of emotions than an explanation of how emotions work. Robert Plutchik (1994) proposed that there is a set of eight emotions that all people experience, anger, fear, sadness, disgust, surprise, anticipation, joy and acceptance. These emotions are innate and directly related to adaptive behaviour that is designed to enhance our survival in the same way as the fight or flight response is designed to help us survive.

Plutchik's theory is based very much on an evolutionary model. It seems to me to provide little room for the cognitive elements that many other researchers have stressed as really important.

While Plutchik emphasized the role of the innate factors and biology, Stanley Schachter (1987) proposed that our environment as well as thought process contributes to the type of emotional experience we have in a situation. According to Schachter's Theory the emotion we recognise we are experiencing comes from a number of interacting events.

Firstly there is some trigger in the environment then this in turn triggers bodily changes which the person senses as a rapid heart beat and muscle tightening. As the patterns of physiological change are similar, the person must make appraisal of the situation and figure out which particular emotion they are feeling. The decision is based on memory of past events in similar situations and their interpretation of what they are feeling. This bears out with 'my' experiences as 'I' can feel very similar physiological symptoms to several different emotions as I have already pointed out. It would seem that I rely more on memory of past experiences to determine the emotion of the moment.

The significance of this theory lies in our evaluation of a situation rather than the situation itself. This can be related to stress. It can be argued that the experience of negative stress can be described in ways associated with emotions such as anger, fear, grief and jealousy. How an individual appraises a situation will affect the emotion they experience – or not in the case of my own dissociation. This suggests that it might be possible to reduce the impact of stress by changing people's cognitive appraisal of a particular situation.

Much of Schachter's theory resonates with my own experience, and is even more evident when flashbacks occur. Something in the environment serves as a reminder or trigger such as a sound or smell or memory and this in turn sets off the physiological signs which then determine which emotion 'I' am sensing. What then kicks in for me is the decision for fight or flight. Past experience has been for flight. not in the physical sense of running away but in the psychical sense of dissociation. If physical flight is not a possibility and fight is also not an option what then is left? It seems

reasonable to expect that the psyche can take control and respond in order to prevent mental or physical annihilation. It seems to me too that much centres on the belief of an individual of what might happen in a given situation as to how that individual will respond. If we take an act of abuse as an example, it is not perhaps only the act itself that can illicit a feeling or emotion but the accompanying beliefs that might go with it. If a child is threatened with reprisals for revealing what is going on, threats against self or family or pets, or it has been instilled in that child that what is happening is his/her fault, then whatever emotion they are experiencing will be reinforced.

So emotions are important for healthy psychological functioning. If expression of them is forbidden or denied then the child will begin to learn to suppress them leaving her exposed and vulnerable. It feels important here to distinguish suppression from repression.

The Penguin Dictionary of Psychology defines suppression as follows –

"In psychoanalysis, conscious exclusion of impulses, thoughts and desires that are felt to be unacceptable to the individual. The classic theory distinguishes suppression from repression in that the former is a conscious process and the latter unconscious…".

It defines repression as follows –

"In all depth psychologies from the classical Freudian model onward, a hypothesized mental process or operation that functions to protect the individual from ideas, impulses and memories which would produce anxiety, apprehension or guilt were they to become conscious. Repression is considered to be operative at an unconscious level; that is not only does the mechanism keep certain mental contents from reaching awareness, but its very operations lie outside of conscious awareness"

I am aware that 'my' repression took the form of dissociation; the question I ask is "How much was my learned suppression of emotions a contributory factor to developing the ability to dissociate?"

Exposure to family and community violence is linked with aggression, depression, posttraumatic stress symptoms and academic and cognitive difficulties. It has the potential to permeate many dimensions of children's day-to-day lives and to erode possible sources of social support. I can bear witness to this as having underachieved at school although I did manage to come out with average academic results. I was also socially isolated from sources of support. Although literature focuses on the deleterious outcomes, many children fare well in the face of exposure to violence. (Margolin and Gordis 2004). I have managed to survive without recourse to the Mental Health system and have functioned well in society. I have again to ask the question "How much of this was due to my ability to dissociate and protect myself from anything unpleasant?" What I am beginning to think is that my ability to dissociate has been an advantage to me at times rather than a hindrance.

When emotions arise, we are not powerless to overcome them: adults actively regulate the extent to which their emotions are experienced and expressed in everyday life. (Lazarus 1984). Often these efforts are aimed at looking and feeling better. They may, for example, distract themselves with other activities or thoughts, seek social support, conceal their feelings from others or reconceptualize events as less emotional or personally relevant. However theories of self-regulation and emotion suggest that some forms of emotion regulation may have unintended consequences for cognitive

functioning. Recent research suggests that reappraisal, which entails changing how we think about an event to neutralise its emotional impact, leaves cognitive functioning intact. (Richards & Gross. 2000) My experience of counselling would bear this out. Exploring the past and being able to distance myself from it and view it from a different standpoint has vastly decreased the incidence of dissociation leaving 'my' cognition intact.

Richards and Gross (2000) have discovered that two common strategies for regulating emotions differ in how they affect people`s memory for upsetting events. They found that when people try to keep negative emotions from showing, a strategy they describe as "expressive suppression", their memory for emotional situations suffers as a result. However they found that this was not the case when people use an approach called "reappraisal", re construing emotional events as less upsetting, for example seeing a forthcoming interview as a challenge or an opportunity rather than a threat. It seems that people are creative and intuitive when asked to control their emotions (Richards and Gross 2000) and have an array of tricks to call on in times of trial. The research conducted by Richards and Gross suggests that how we regulate our emotions in times of life`s trials and crisis' matters. Some approaches are better than others which led Richards and Gross to wonder if different emotional regulation strategies have consequences for cognitive functioning, including memory. Their subsequent research discovered that their research participants in the expressive suppressive condition showed poorer memory than did control participants, despite no difference in the two groups' emotional experience. However this was limited to verbal memory. The suppression group remembered fewer details verbally than the controlled group. In contrast visual memory was the same for both groups. This led to

the suggestion that that self-monitoring demands similar cognitive resources regardless of the intensity of the emotions being suppressed. Their study showed that people who tend to regulate emotion by suppressing emotional expression remembered fewer recent emotional situations than people who relied on appraisal.

This opens up an area of discussion around dissociation. Whilst I see dissociation as a form of "expressive suppression", possibly in the extreme, which led to 'my' inability to recall clearly past events and feelings, they were not entirely lost as memory was delegated to my alters. It seems they have held memories of events and emotions which 'I' was forbidden to express and denied, and subsequently continued to not allow myself to express; a learned behaviour pattern. I can also identify with their findings in that 'my' recalled visual memory is good. I can remember small details like a button missing from a shirt during one episode of abuse. I am called to ask here if peoples' experiences of flashbacks are evidence to support Richards and Gross' theory that visual recall is easier than verbal. When recalling the past I have often experienced "something coming through" and this has usually come through in the form of a picture first.

It seems to me that if we deny expression of emotions then we are not experiencing the fullness of our existence. We are not free to be truly ourselves.

5.4.2.. Summary

Denial of rights and feelings can have a disturbing effect on the individual and her psyche. It can lead to suppression of emotions and ultimately in cases of severe trauma leading to repression. As Richards and Gross (2000) have found suppression

of emotions can interfere with verbal memory recall and this could have implications for the jury system. Experience has shown me that suppressing emotions and not llowing them expression only leads to the psyche finding other forms of release. In my case in dissociation, in creating alters to do the 'feeling'

5.5. PSYCHOLOGICAL TRAUMA AND LEARNED HELPLESSNESS.

Apart from the inability to allow myself to feel at any real depth there came with this a sense of helplessness. (see table1) There appeared, as a child, to be no-one to whom I could turn to, not even God, and even if there was I feared that I would not be believed and I was often told of the consequences of telling. (see table1.) In the face of the threat of imprisonment, violence or death the sense of helplessness is overwhelming.

A. All I could…all I could…I just had this sense….ever since I listened to it [reference to the previous tape]of…and it must have been….I remember it so clearly….just this sense of….being in a place where there was no hope…and all that was left was patience. There was absolutely no hope.
K. All that was left was patience…..What kind of patience?
A. Just waiting.
K. Mmm.
A. Just waiting…there was no hope. There was nobody. There wasn't anybody that was going to rescue me.
K. Mmm
A. I would just have to wait for things to change……There was this horrible feeling…..I suppose it was like despair really….(silence)..There was just no point in hoping.
K. There was no point in hoping because?
A. There wasn't anybody or anything……(silence)….I was so lonely.
K. Lonely and alone. (Tape 54)

A. I used to….I used to ask God to make it all stop and of course it never did….and I used to plead with him to make me pretty and of course he never did….so I stopped asking. (Tape 34)

It took several years for me to accept that what I told **K** would be believed. It often took me a long time to reveal things that I began to remember but his acceptance began to give me hope.

K. I…I have said this to you before…one of the things that always strikes me in our work together over the last seven…six years….is that it has been totally consistent…and as I said this to you last week as a counsellor you know this from your own experience, you're looking for inconsistencies…it's one of the things you look at…there's never been any inconsistency. Your testimony as it were is totally consistent…and congruent. The various bits fit together …I…I…keep saying I haven't a shadow about anything you have said to me…never have had actually. (Burdess 2000. Tape 13 MA)

Again I think if the reader was able to hear the tapes the sense of helplessness could not fail to be heard in the tone of voice, the sighs, and the silences and in the times when **K** can find no response. Sometimes I am aware of his sense of helplessness. So much can be discerned from felt senses for which language can so often be inadequate. **K** is lost for words during the session when I am telling him of the incident where I am made to stand in the hall for two days but it is his voice tone which says so much.

K. . You stood there for two days?...Did you say you stood there for two days?...(long silence)….Did you not go to bed?....(silence)…..Were you fed?....(silence)…A?.....No?... Did your mother do that to you?....(long silence)….I'm aware you're not talking to me….(voice very gentle…silence)….You said you didn't talk because you had no-one to listen and I'm listening….(silence)….and I've been listening for a long time now….(silence)…..I'm sorry that happened to you……. you….(silence)…I just find it…I said I believe….I just….find….it….it's……incredible….just….the….notion…of……two…..days……. standing…..there…(long silence)….

(Tape 24)

5.5.1. Discussion.

Several authors (Flannery 1987b; and Walker 1989) have used the concept of "learned helplessness" (Seligman 1975) as a paradigm for understanding the continuing sense of lost personal control reported by some victims of repeated trauma (e.g. victims of

incest, battering, combat and sustained torture). Walker (1989) uses this construct to explain why some women remain with abusive partners and suggests that such helplessness may be accompanied by low self-esteem, a general disinterest in life and by a possible increase in additional victimisation. Seligman (1975) working with 150 dogs defined the construct of learned helplessness. He placed in a shuttle box dogs who had previously been subjected to shocks to their paws and dogs who had not previously received this treatment. He observed that those who had a history of inescapable shock remained passive but those who hadn't made every effort to avoid the pain by jumping around the cage. Seligman hypothesised that frequent experience with a lack of contingency between outcome and response led the dogs to assume that escape was futile. Human research studies (Garber and Seligman1980) suggested that humans develop similar helplessness including loss of skills, isolation and passivity. He later expanded this theory, since not all victims became helpless, to include three other factors – that if the perpetrator took excessive control, that the victim assumed that the event would be of a long duration and that it would negatively influence subsequent actions then helplessness would ensue.

Flannery and Harvey(1991) suggest that this is a limited view and offer an ecological model for understanding and explaining behaviours cited as learned helplessness succinctly put as person x event x environment. It acknowledges that people react to potentially traumatic events in a widely different way and that not all events are viewed as traumatic to all people and that response and recovery depend on a complex interaction of person, event and environmental factors. Factors include the age of the victim and stage of development and their pre-traumatic coping capabilities and cognitive abilities. It also includes relationship to the perpetrator, attitudes, values and

support systems. They suggest also that event variables such as the nature, the duration, frequency and severity are strong considerations. Environment variables such as degree of safety and protection, community reactions, attitudes and values in society and in the victim's community also prevail.

This resonates with 'my' own experiences and in a sense helps to explain perhaps why 'I' needed to dissociate. My first memory at about the age of two is of sexual abuse. The chances are I was a lot younger when it started. I therefore had no pre-trauma coping mechanisms to resort to. It was perpetrated by family members, friends of the family and strangers who reached into any support systems that might have been available. I was being taught values at a Catholic school which were in conflict with each other – that sex outside of marriage was a cardinal sin but I had to honour and obey parents and adults. It was my duty to forgive and "turn the other cheek". The nature of the abuse and severity can only be described as brutal and it has taken me a long time to acknowledge a comparison to the accounts of survivors of concentration camps, something which remains difficult. The accounts of these survivors and indeed the accounts of some prisoners of war, are harrowing and I feel unworthy to be making such comparisons, never-the-less I can identify and empathise with much of what they recount in how they responded to and felt during their ordeal and subsequently afterwards. It happened over many years. It took place in the 50's and 60's at a time when abuse was neither acknowledged nor, worse still, believed and parents were expected to chastise their children. Women were considered to be responsible if they were sexually attacked or harassed after all, men 'couldn't help it'. There was no sense of safety in a locked room with no escape or in a graveyard and who would protect when my perception was that there was no-one to trust? Given

these factors is it any wonder that dissociation was a way out? I'm tempted to postulate that dissociation was an alternative to helplessness, given that 'I' had no prior coping experiences and mechanisms, as well as a way of dissipating emotion. I would agree with Flannery and Harvey (1991) that the choices that victims make have a great deal to do with "ecosystem of resources that are available to them as they try to shape their fate" (p377).

That sense of helplessness is indeed a key factor in keeping oneself in a kind of prison. (see table 1) In not being able to help oneself there is little or no movement. If there is no movement what is the point of feeling? Emotion is good if we are free to respond to it, if not it is like a canker that eats away. To survive it is better not to feel at all, that involves living the reality.

Flannery and Harvey (1991) list alternative ways of understanding the helpless behaviour which keeps a victim passive and hence locked into a behaviour type. I have a sense of fitting into each of these suggestions. (see table 3)

i) Lack of Options – helplessness may be because there is a sense of hopelessness because of a lack of options. Seligman (1975) notes this as the victim sees no reasonable escape. The helplessness emanates from the victim's despair and from an ecosystem that does not offer alternatives to continued victimisation.

A. …there was no hope. There was nobody…There wasn't anybody that was going to rescue me…there wasn't anybody or anything. (Tape 54)

ii) *Lack of Skills.* – helplessness in the face of sustained trauma may be because the victim has no learned skills to cope. Questions like "Who do I tell?" "Who can I trust?" "Where can I go?" are difficult enough for an adult to answer, children may

have the added difficulty of not even being able to formulate them. 'My' abuse started at a very young age possibly before I was cognitively able to formulate questions or to hold opinions and beliefs.

iii) Internalisation of Blame. – helplessness can appear when the victim sees themselves as the cause of the trauma or that they deserve no better. Janoff-Bulman (1985) poses that early and recurrent victimisation may engender "characterological self-blame" where the individual assumes that continued victimisation is justifiable punishment.

A. …he told me I made him do it…that it was my fault…If I told anyone I would go to prison.

(Tape 32)

H. If I tell anyone I will die. (Tape 20)

iv) A Sense of Altruism. – helplessness here comes, for example, when the victim of abuse has a notion that keeping quiet will protect a brother or sister from abuse or will spare the mother grief. The role of victim hood is accepted in order to spare others.

Although I had no siblings to protect and was unaware of any other child being involved I now have a deep sense of protecting my own children from my history. In revealing what happened to me there could be repercussions in the family now so in a sense I am continuing the role of victim in order to spare the extended family pain.

A. I don't want my children to have this as their legacy…..they [the abusers] are probably all dead now. If I tell my story the only people I will hurt are their families and what right have I to cause them pain?

(Tape 32)

Herman (1992) believes that these concepts tend to portray the victim as simply "defeated or apathetic" and that the reality is that there is a livelier and "more

complex inner struggle" usually taking place. She feels that in most cases the victim hasn't given up, rather that she has learned that she will be constantly watched and that any sign of rebellion/opposition will be thwarted and that any sign of failure will incur wrath: any exercise of initiative will be viewed as insubordination hence she will be hyper vigilant expecting retaliation. She recognises that prolonged captivity undermines or even destroys a sense of a "relatively safe sphere of initiative", in which there is some tolerance for trial and error. To someone chronically traumatised there is no room for mistakes as they bring with them retribution. (see table 1)

A. I remember going up to my room and sitting on the bed waiting….did I put my pyjamas on ….when they didn't come ….I sat in the corner of the room…not knowing what was the right thing to do…what would they want…..I spent the night in the corner….I couldn't risk getting into bed in case they were coming……I was scared I might fall asleep and wet the bed.

(Tape 32)

I can recognise Herman's theory well. I spent most of my life hyper vigilant and am very easily startled even now. I had to be one step ahead of them. **K** often reassures the personalities when they are startled by noises outside the room but sometimes gets frustrated when 'I' react to outside noises. I think he felt that by now 'I' should feel secure enough in our sessions not to feel threatened by outside sounds and on one occasion interpreted my response/look as "contempt" for the people outside saying they had a right to be there. Fear comes in many disguises. 'I' may feel relatively safe inside the room and with **K** but he has no control over the unpredictability of other people no matter how well he may feel he knows them. 'I' know only too well how unpredictable people can be.

I would often think of ways of escape and would sit for hours on end in my room planning how to kill my abusers. Nothing came to fruition because I could see no way

out. There was no-one to turn to, nowhere to go and God said it was wrong not to obey adults and if you did wrong you didn't go to heaven. For me, a Catholic girl, that was the ultimate rejection. None of this stopped me thinking and the inner struggle was endless.

However, I do recognise times when I gave up this struggle and just waited – waited for what I'm not sure. These were the times when, as I have described, there felt to be no hope. I suppose I had lost the will to live. I gave up talking and eating and seemed to just go through the motions of existence.

A. I used to stop talking for long periods. (Tape 24)

During those times I can identify with the "Mussulmen" of the concentration camps. As Wiesel (1995) explains they were the people in the camps who gave up and waited to die.

It was a form of passive suicide. One wonders what was going through Victoria Climbie's mind when the week before her death she gave up talking!

But Wiesel (1995) notes that the German's psychological methods often failed.

> "They tried to get the inmates to think only of themselves, to forget relatives and friends, to tend only to their own needs, unless they wanted to become "Mussulmen".But what happened was just the reverse. Those who retreated to a universe limited to their own bodies had less chance of getting out alive, while to live for a brother, a friend, an ideal helped you hold out longer"
>
> (p80)

It seems to me that Wiesel is recognising that as humans we need a reason to live, a purpose, a raison d'etre and even as a small child I had a sense of this. Despite the

times when I 'gave up' most of the time was spent in inner rebellion and with a deep sense of survival.

A. No…I think the reason for that is because….I thought when I was….I thought that was giving up…I can remember as a child….having this inner fight…I'm not going to die…I'm not going to lie back and let it happen.
K. I remember you saying that…
A. …because I thought that was giving in.
K. Yes I think you were right….because I think you would have died…

(Tape 28)

If there was any dying going to happen 'I' was going to do it. It would be my choice.

It feels similar to what Frankel (1964) describes of some of the inmates of Auschwitz.

"We who lived in concentration camps can remember the men who walked through the huts comforting others, giving away their last piece of bread. They may have been few in number, but they offer sufficient proof that everything can be taken from a man but one thing: the last of the human freedoms – to choose one's attitude in any given set of circumstances, to choose one's way."

(p65)

I can understand Herman's belief that some theorists have mistakenly applied the concept of 'learned helplessness' to the situation of those who have been chronically traumatised as she believes there is a more complex inner struggle. I am not sure it is as simple as this. I have experienced the inner struggle she describes and the desire to maintain some order of control despite not actually activating it but I have also known the depth of despair of not seeing a way out of feeling totally helpless. It seems to me that we can oscillate between this state of 'learned helplessness' and a state of inner struggle. Perhaps as Flannery and Harvey (1991) suggest we need to look more closely at the ecological influences.

In breaking down this barrier of helplessness and exploring the possibility of what it would be like to feel in 'my' own right, the challenge of therapy is in teaching new

skills and in challenging prevailing beliefs. The result I hope will be the opening of the 'prison' door.

5.5.2. Summary

Feeling helpless is the state of not having the power to help oneself. Flannery and Harvey's (1991) ecological model of person + event + environment for explaining behaviours seems to bear witness to my own experience. My thoughts with this theory are that with the combined lack of options available and the lack of skills contribute to the need to find some control. A sense of altruism and internalisation of blame can be ways to provide some control in an otherwise control-less situation.

5.6. SHAME.

Part of the sense of emotional imprisonment is due to the inordinate amount of shame that pervaded my life. There was a sense of deep shame surrounding the abuse but also around the fact that I dissociate and am therefore 'different' to others. This was compounded by the fact that dissociation is seen as a mental disorder as in the DSM-V and the stigma around mental illness was acute in the social sphere that I was brought up in.

This was the second finding for me which at this stage in therapy was proving to be an overriding feeling and will be dealt with separately in the next chapter. It felt to be a key to the door of this emotional imprisonment.

At this point I felt it would be of benefit to look at what captivity means. Being in an emotional prison has parallels with the experience of captivity

5.7. CAPTIVITY.

"Environmental influences can start at a very early age to determine whether a person will go out for experience or withdraw from the world when seeking a reassurance that life is worth living."
(Winnicott 1988b:128)

It is not easy to unlearn years of experience and perspective so as to try and understand what it must feel like to be a baby or infant: a state where there is no knowledge and not enough lived experience to have created memories and learning. As adults we have many frames of reference and yard-sticks to measure things by. For example, we know that daffodils herald the beginning of spring and we can visualise snow in winter even in summer because we have memories which support our knowledge. However a baby has no frame of reference and has to learn to set her experiences in perspective. Adults may know why they feel the way they do, babies do not. A baby may learn that sucking can be pleasurable if it produces something warm and sweet and that it will take away the feeling of hunger and so will resort to sucking her fingers or thumb in order to simulate that comfort. It may also learn that crying is of no avail if she is not responded to and resort to staying silent.

Winnicott (1965b:84) describes three states of dependency, the absolute dependence of early infancy, relative dependence when the child learns to tolerate absence from its mother and 'towards independence' when there is relation between the individual and the environment. Unlike dependency the concept of attachment applies

throughout life. Bowlby's attachment theory (1969, 1973, 1980) states that secure attachment is seen when the child can use its mother as a base to explore the world, being willing to be apart from her for short periods. These securely attached children become adults who are comfortable with and confident in those to whom they relate. Anxious attachment is applied to those who cling to and are dependent on others because of their anxiety about the reliability of primary care givers. Detachment is the third way Bowlby describes of dealing with relationships and is particularly likely to result from long and repeated separations from key figures in childhood. It is the defence against the anxiety and pain of anticipated loss in relationships.

He states that in the reaction to nurturing which is either neglectful or over-indulgent, a child may become withdrawn or clingy, both defences seen in adults who 'cling' to drugs/alcohol/food or who live in a fantasy world. As a child 'I' withdrew from the 'outside' world and resorted to books to create a 'fantasy' that would compensate for the reality. **Susie** talks of her love for books.

S. I've got lots of books.
K. Have you?...Uhuh….at home?
S. Mmm.

K. In your room?....Do you like reading?....It looks like you like it a lot…..What do you like reading?
S. I like the 'Famous Five' books.
K. Uhuh….The 'Famous Five' books.
S. Mmm…..They go on lots of adventures.
K. Do you go on their adventures with them?....Do you?
S. Mmm. I like the one on Kirrin Island.

(Tape 28)

Keenan (1992) when recounting of his sense of aloneness and his fear of an "enemy within" talked somewhat in depth of coping by returning to

"an old strategy of thinking through the books I read as a child……I particularly remember many hours spent thinking about the story of Robinson Crusoe."

(p73-74)

Detachment was the beginning of dissociation and in doing so I was creating my own world of isolation which probably, in hindsight, was the start of a sense of captivity. I was caught in my own solitary state and did not feel free to participate fully in the world of others. This was compounded when I realised that what was happening to me was not happening to my school friends and so my felt sense of not being able to join the outside world developed to not deserving to be a part of it.

K. Now hang on….what I wanted to say was…they told you so much…that it was your fault….that you were making them do what they did…this was because you were as you were and they were as they were….therefore it seems to me that …that what you….and you can come back at me if I'm wrong…that what you internalised here was a bigger and bigger sense that there was something wrong with you….that you were fundamentally bad…and as you discover that it's not happening to the others…then again…it seems to me that what you did…was that sense of you being bad became greater and greater and greater…is that…am I on the right lines?
A. Yeah…(silence)
K. And they carved it onto your soul. (Tape 12)

What was happening was both degrading and humiliating. I could not escape it physically and I could not escape from the immorality of it all; all I could do was to find a way to escape it psychologically.

"Prolonged and repeated trauma ….occurs only in circumstances of captivity. When the victim is free to escape, she will not be abused a second time; repeated trauma occurs only when the victim is a prisoner, unable to flee and under the control of the perpetrator".

(Herman 1992 p74)

According to Herman total control of a victim is not complete until she has been

"forced to violate her own moral principles and to betray her basic human

attachments." (p82) It is psychologically the "most destructive of all coercive techniques" (p83) as once having succumbed the victim then comes to loathe herself. As a child I suppose I hadn't had much lived experience to develop moral codes but I was aware of an innate sense of it being wrong and I hated myself.

K. I've heard you say before that you knew what was happening was wrong…am I right there? I've heard you say that before this isn't right.
A. Well it felt wrong. I don't think I knew….I don't think I cognitively knew it was wrong. It felt wrong….It wasn't nice….it wasn't…
K. It felt wrong in here (pointing to his heart)
A. Yes…because at that stage I thought it happened to everybody…so I didn't know that it was wrong….
K. It was the thing that happened to human beings, it wasn't very nice and it wasn't pleasant, it was painful yet it was what human beings went through?
A. ..so I didn't know that it was…for want of…legally, lawfully wrong. I just thought that this is what happened but it felt wrong…..even at a very young age I knew the difference.

(Tape 12)

A little later….

A. And then you see being taught at school….sex before marriage is wrong…you know the usual…
K. Oh yes…usual Catholic stuff…..so what I've heard you say is that right as a small child you knew…your instinct was that it was wrong…not only was it not pleasant or whatever…singly unpleasant and painful…you knew it was wrong. There was a sense that what was happening was wrong.
A. But I still did it and I hated myself. (Tape 12)

Herman is right. In having no place to escape to I was in a sense their prisoner. Once I had lost all respect for myself I was their sacrifice. The sense of shame was and still is inordinate.

Wiesel in his account of his time in the concentration camps described the despair and how staying with his father and keeping him alive was what got him through most of

his ordeal. What struck me were his honesty and his remorse when he abandoned his father. He had broken his moral code and has lived with the consequences ever since. Going to look for his father he thought….

" 'Don't let me find him! If only I could get rid of this dead weight, so that I could use all my strength to struggle for my own survival and only worry about myself.' Immediately I felt ashamed of myself, ashamed always."

(1960)

I can identify with that sense of shame so well and recognise it as a key to a release from an internal prison.

In some ways dissociation cuts the individual off from reality and therefore by its very nature is a form of captivity. Not being aware of the reality of a situation separates the victim from factuality, keeping them away, keeping them out of contact. Presenting another – an alter - to experience the reality prevents the victim from the knowledge and, while this is done to protect, it is separating her from whole truth thus detaining her in self exile.

It is acknowledged that under extreme conditions of early and prolonged abuse, some children, and perhaps those already endowed with a strong capacity for trance states, begin to form separated personality fragments with their own names, psychological functions, memories, emotions and perceptions. (Herman 1992: Putnam et al 1986: Ross 1999; Kluft 1982).Hence dissociation becomes not just a defensive adaptation but also a fundamental principle of personality organisation (Herman1992). These personalities make it possible for the abused child to function resourcefully keeping both the abuse and her coping strategies outside her ordinary awareness. I can only

describe it as like living in a parallel universe. The discovery that others were not doing what I was doing created a huge divide, I was existing in one world and they in another. It is similar to the 'gold fish bowl' experience when we can see or sense the world going on around us but feel detached from it for some reason, that there is a barrier between self and the rest of the world. It is something that prisoners often describe, that life outside the prison walls goes on as usual without them, that they are living in another world.

Wiesel(1995) describes a sense of separateness in him whilst in the camps, a form of dissociation which I can so easily identify with.

> "That night someone within me, my other self, told me it was impossible that these atrocities could be committed in the middle of the twentieth century while the world stayed silent. This was not the Middle Ages. .....I could see everything, grasp it and register it, but only later would I try to put in order all the sensations and all the memories. How stunned I was, for example, to discover another time outside time, a universe parallel to this one, a creation within Creation, with its own laws, customs structures and language. In this universe some men existed only to kill and others only to die….It was if all unfolded according to a plan decreed from the beginning of time".
>
> (p78)

I could not understand how I could be living my life alongside those who lived theirs so totally differently and if adults with previous coping strategies to fall back on need to resort to disconnecting themselves from their painful reality is it any wonder that a complete dissociation in a child takes place in order to cope?

Herman (1992) observes that during prolonged confinement and isolation, some prisoners are able to develop trance capabilities which she says are ordinarily only seen in highly hypnotizable people. She adds that in addition to the use of trance

states, prisoners develop the capacity to restrict and suppress their thoughts, particularly to thoughts of the future. Wiesel (1960) talks of how seasoned prisoners would teach new inmates this art through meditation, prayer and chanting. Keenan (1993) describes his ability to do this through resorting to entering into the world of fiction, Ratushinskaya (1988) by entering into her poetry. What seems to me to be going on here is that people who are not "free" to choose their own experiences and who are faced with intolerable situations will develop ingenious ways to protect their psyche. When faced with the intolerable we need to find ways to cope. It appears that children have a greater ability to fully dissociate and develop that dissociation into the phenomena of DID (Kluft 1982: Ross 1989). Jaffe (1968) noted that certain patients who had been imprisoned in concentration camps showed a traumatically acquired personality change distinguished by states of altered consciousness in which highly traumatic, dissociated material emerged. The dissociated states occurred in short attacks. She concluded that these altered states of consciousness were of a dissociative state, the precursors of which had already appeared during imprisonment. Whilst not displaying full blown DID they were displaying definite signs of a dissociative ability.

Whereas political and legal captivity are apparent there are other forms of captivity that often go unseen – that of the battered women and the battered and abused children. The physical barriers here are rare but the invisible barriers can be just as devastating. Women can be held captive by economic, legal, social and psychological submission and children purely by there dependency. (Herman 1992). Violence or the threat of it is also an unseen barrier. My personalities often show their fear in telling **K** their story because of the perceived consequences of telling anyone what was

happening. They often ask for reassurance that he will not tell anyone what they reveal, **Susie** in particular

S. I don't like her very much
K. You don't like her very much….Is she bad?...Is she bad?....OK…I believe you….if you tell me that your m……is bad then I believe you.
S. You won't tell will you?
K. No. It's alright. There's no need to tell anybody else….you can tell me….so let me ask you again, could I help you get away?....(silence)…
S. They'll hurt you. (Tape 12)

K. Oh….I didn't say you have to like her. I said do you like her?
S. You won't tell? (Tape 24)

S. You mustn't tell.
K. Uh huh….and you hate her I know that….
S. You won't tell anybody?
K. No I won't….no I won't. (Tape 28)

There is no need for a physical restraint when fear will do the job and it is less apparent to the inquisitive than bars or a lock and key. When that fear extends beyond the actual experience into later life even when the abuse is over then whatever coping strategies were developed to cope with the actual situation will remain to cope with the ongoing fear.

A. It's as if there is something there haunting me.
K. Uh huh….you almost give it a personality.
A. That's how it feels….It feels like some sort of malevolent spirit that's controlling everything.
K. Malevolent in terms of being against you.
A. Yeah…(silence)….I know this might sound stupid….but I can remember one of the threats they would use was…if you tell or if you don't do something or whatever….the threat was I'll come back and haunt you…I wish I had a pound for every time S said it!...and my mother…(silence).
K. …(softly). Did your mother say it as well?..(silence)…
A. …and I suppose doing this research I've often wondered what it was…apart from the actual awfulness of what was happening…..what actually sort of drove me or

prompted me or whatever….to dissociating…and it wasn't…it was fear! There's no two ways about it.
K. Uh huh….
A. …but it wasn't just the fear of actually what was physically happening…it was the fear of what they said, and what they threatened what…
K. Right.
A. ..they said they would do.
K. Right…(silence)…so the fear was very…very much generated by…no let me re-phrase that….quite a powerful element of the generation of fear was the threats that they made….what would happen to you..
A. Mmm….because they always made it sound as though it was worse than what was actually happening.
K. Yes…yes…and it sounds like they were also saying A that…that they had power to ….to make their threats come true in perpetuity.
A. And I know rationally that's not true now….but I can't help every so often…it just comes over me like a…that they are totally in control…
K. Uh huh…
A. …and they still are…and I think the only way…I mean I don't know whether I was consciously aware of it as a child but it seems to that the only way that I could break that control was to dissociate.
K. Yes. (Tape 34)

According to Herman(1992) fear is often increased with "inconsistent and unpredictable outbursts of violence and by capricious enforcement of petty rules" (p77) It was often my experience that a beating was imposed for the slightest or no real reason. It was there to serve the purpose of communicating their total control and omnipotence. I was just thankful that I survived – thankful they stopped before they went too far!

If you are led to believe they can reach you beyond the grave then that will ensure your silence and keep you within the confines of the invisible prison they set up. It also ensures that you will go to any lengths to maintain an edifice of secrecy – the same secrecy that was in place when the abuse was going on. The secrecy that was held in place then because you were led to believe you were bad and that it was your fault is held in place afterwards by the shame.

In dissociating all my emotions are kept from conscious experience and this reinforces the sense of imprisonment and mere existence. The task of therapy is to eradicate the fear and turn the key of shame to initiate a freedom of expression and then – life.

5.7.1. Summary

Whilst captivity suggests a form of physical custody, emotional imprisonment has no physical barriers but the effect is the same.

A single traumatic event can occur almost anywhere; by contrast repeated trauma occurs in circumstances of captivity (Herman 1994). When a victim is free to escape, abuse will not be re-occur. Repeated trauma occurs when the victim is a prisoner, unable to flee from her captives and is under their control. These conditions are usually associated with prisons and concentration camp but can also exist in religious cults, institutions of organized sex and also in families. Children can be held captive by their dependence and women or vulnerable adults by economic, social and psychological subordination (Herman 1994).

Emotional imprisonment goes further keeping the victim locked within herself and is influenced by many factors creating what I see as the cycle of dissociation.

5.8.TRIANGULATION..

I offered this section to **K** once it was written to ask for his thoughts and opinions and to see if he recognised or had any sense of what I had discovered. His observations were interesting and very much from the viewpoint of the therapist. He could see clear movement in the therapeutic process which if I'm honest was reassuring even though it was not something I was looking for. However, from the therapist's standpoint I am not surprised he would look at process and for evidence of progress. Again this is an advantage of taping the sessions. He could also recognise a change in the way 'my' personalities were responding.

A. I need to know what you think bearing in mind it's stuff from two…three years ago, not now…it's back then not now…if you know what I mean….
K. Uh huh….no..no…indeed…I…understand….
A. …that's the difficulty of it…
K. Well it seems to me that we've moved on quite a distance really….um…in that these sub personalities, or what ever name you give them…alters, or whatever you call them …they seem to be more integrated into your overall process….
A. Mmm.
K. …than they were …you know?...and interestingly the anger [reference to the work we
were currently engaged in] in you has as we have suspected been building in you a long
time. It was certainly around.
K. I suppose what strikes me is the input of the little ones [K's collective name for the younger personalities] has become more ….what's the word….it almost feels like their in put is…back there is still a bit awkward…
A. Yes….right…I see what you are saying.
K. …whereas what I feel now is that it flows.
A. Mmm…I think they are probably more at ease.
K. Yes. I think so. I can remember the lost buttons…um..and putting them in an envelope and the distress that caused…so maybe they are more at ease…..and I think getting more able to tell what they need to tell.
A. Yes.
(Triangulation tape. Tape 140)

Looking at the sense of captivity we talked around my need to remember as much as possible about what happened to me as a child and therefore to deal with the consequences. This in itself felt liberating for me throughout therapy, actually being able to tell details and I acknowledged how difficult that has been for **K** at times. We had a discussion about how for some clients the need to know details and to talk about them is important for their understanding and recovery and how for some the events and details of the past were irrelevant to the work they needed to do and how this decision was for the client to make and not to be imposed on by the therapist. I acknowledged that for years memories would come back through a "mist" and would take time to come through. However over the last few months I seemed to be able to have a 'normal' recall of memory; the sort of memory recall that comes back when

someone reminds you of a forgotten incident. I also admit that over the past couple of weeks something seems to be coming through the mist again.

A. For me…I need to know…
K. Sure….you're different.
A. I need to know…and I sort of need to ask questions but…(laughing)….not that I get any answers but I need to sort of say…..so I know there's something pushing through but…
K. ..you don't know what it is.
A. I can't….
K. …get hold of it.
A. No.

(Triangulation tape. Tape 140)

Looking back now I can see that the memories that seem to emerge through a mist are the ones that have been buried so deep and hence have had the worst impact on 'me'. Those that come back with less strain are the ones that although are still hurtful do not present quite so much the pain or the fear associated with those that seem to be so deeply buried. This process in itself seems for me to be a kind of liberation. Coming through the mist seems to release memories that have been imprisoned for so long deep in a part of me that has felt unreachable in the past. It seems to me that we all see what we want to see according to our needs at the time which is apparent particularly with those of us who dissociate; dissociation being the ability to take one's mind away from one's own immediate situation or surroundings. Coming into counselling was for me the start of a search and a journey into truth and a coming to terms with 'my' own reality. We all wear masks. Beneath the complex layers of our own individual mask of self-created illusion, which we call 'our truth' are other complex layers of our 'reality'. The process of dipping into these hidden truths takes us from the tip of the iceberg which is the conscious mind into the realms of the unconscious mind below the surface. I have to acknowledge here that much of 'me' lay below the surface. Now

that I have dipped into this realm of the unconscious I have begun to discover 'my' true self, and the deeper I go the more I come to realise that the difference between us as individuals begins to disintegrate. It seems to me that we are all very much the same below the surface. To go even further into the realms of the unconscious we eventually discover that at a very deep level we are all connected. This is what Jung (1943) called the "collective unconscious". When we reach this level then we learn we are all one. If there is such a thing as absolute truth then this is where I think I expect to find it.

In some ways I see myself as fortunate; fortunate enough to be following this very difficult and traumatic path to these hidden realms in the hope to discover the consciousness of oneness and the joy and divine love for all mankind. If there is an absolute truth then this surely is it. This is the absolute truth that I can call God – love, joy, bliss and above all freedom. I see that they can be one and the same thing and that we as humans are the material manifestation of this. I hope that when this oneness is reached there will be the ultimate freedom from fear culminating in integration not just of self but with all humanity. To be at peace with oneself is to be at peace with the universe. – total freedom.

K also makes comment on the integration with theory

K. You seem to handle the theory very well A…it seems to me.
A. Does it make sense?
K. Yes….it does….and you seem to challenge it in what seems to be a very reasonable and forthright and thoughtful way….because there can't be anybody ….um…it seems to me…who has the …I'm thinking in the theoretical context here…there can't be anybody who has the insight that you've got…I mean in terms of those who have written it up.

(Triangulation tape. Tape140)

CHAPTER 6.

RESEARCH DISCOVERY – 2 - Shame.

"Where there is shame there may in time be virtue".

Samuel Johnson.

6. SHAME

Experiences of acute shame often leave painful traces.

> "The unluckiest hours in our life are those in which we remember the past blushing – if we are immortal this is what hell must be like" (quoted in Hultberg 1988:115).

Shame wears many masks and I'm sure many of us know only too well the sleepless nights and the agonising days we have spent reliving events that have caused us shame. How often have we cringed with embarrassment at things we have said and done without thinking? Often we can put things right, often we cannot.

The most traumatic experiences of shame usually occur in childhood and can often leave a sense of emotional defeat that can pervade the rest of our life (Jacoby1994). Something that has caused a child to experience shame can colour her view of the world as an adult. For example a woman who was often receiving compliments about her spoken voice could not be persuaded to read in her local church. As a child she was made to read out loud in class and when she made a mistake over a difficult word caused the class to laugh at her. To add to her embarrassment she was accused by the teacher of deliberately trying to disrupt the lesson. This was then relayed to her mother at the end of the day, who then proceeded to castigate her over the shame she had brought on the family by her behaviour.

I have always had a sense of shame about my past even though I was not sure what that shame actually was. I had no memory before the age of 9 years before coming into counselling. That in itself seemed to me to indicate that there was something in my past I was trying to hide and having completely blotted out memories further seemed to indicate the depth of that shame. (see table 4) Slowly, in therapy, that past has revealed itself and that sense of shame has been magnified.

How quickly we feel ashamed and how deeply, depend on the measure of tolerance we are able to conjure up for our dark sides. It depends on how we have been met and responded to in the past. Has our shame been reinforced or has it been disseminated? I was aware of 'my' shame but had not seen its depth and the effect it has had in my life until listening to the tapes. Looking at this finding I wish in hindsight that we had indeed videoed the sessions as much is lost with not being able to watch the interaction between 'myself' and **K** and the personalities and **K**. For a long time I was unable to give eye contact with **K** and there was a fear in me that he would see this as perhaps me not telling the truth. (see table 4) It is often said that the police consider the inability to give eye contact is a sign that a person is not telling the truth and are trained to look for this when interrogating suspects. Giving eye contact with **K** was, and sometimes still is, unbearable. I was taught that our eyes are the windows to our soul and I could not bear him seeing into that burning shame etched onto 'my' soul. I thought it would get easier with the telling of my story and with the building of trust but it feels harder as we go along as my respect for him gains ground. What he thinks of me is more important now than ever. What I think I am going to see on his face I don't know because the reality is so far that he has shown nothing but empathy

and respect. At times too he has shown passion and anger and distress but not as a direct cause from me. It has been a response to the injustices he has heard. Audio tapes also miss the body language and the physiological responses such as blushing and sweating. However if listened to carefully they do portray much in the long and sometimes agonising silences and the gradation of tone or nuances.

Being ashamed wreaks terrible havoc with sense of self. There seems to have been a real need to hide things from every one which I learned from my mother, to present a united and almost perfect front to the outside world. (see table 4) What I realise now of course is that in doing this my mother was concealing the truth about our life but I took it on board as her hiding my inadequacies and her disappointment in me. In this extract we are looking at my fight not to retreat into my own world by staying indoors.

K. A What is it in you that actually fights against not going out….that actually fights to keep the show on the road as it were? What aspect of you is that?
A. This fear of failure I think….The one thing I know that I've inherited from my mother is the need to make everything look OK…I'm beginning to recognise that.
K. Mmm…to keep the show on the road…to keep the edifice in position….keep everything moving?
A. Mmm. I've always done that from being so small…I've hidden the evidence of everything….of anything that was going on….

(Tape32)

And a little further on…

K. Uh huh….so in a sense in barricading yourself behind the front door you would be doing the opposite of what your instinct is and that is to keep the edifice in position. You would be admitting that there is something wrong.
A. And my desperate need….as a child and even now is to prove that….I'm not the things they said I was….I'm not….I'm not crazy. I'm not…and this…..and it's all linked to this ….sense of being believed, this sense of ……..this sense of shame…(whispered).

K. There is a sense of being believed A. There is a sense you almost said shame I think….uh huh?
(Tape 32)

This admittance of shame leads to an opening up of the real sense of shame I had as a child at not being able to meet my mother's expectations. Looking back now I can see how unrealistic my attempts were at trying to aspire to her desires of me. I was not even the right gender! My experience of shame is a feeling of inadequacy at the core of self. Shame is felt for being a mistake. (see table 4)

A. One of the things that sat so strongly with me….one of the things I've never really forgotten was…my sense of shame at not being what my mother wanted…not reaching her ambitions for what a …her child should be…..not…not…not being who she wanted.
K. This is your adopted mother you are talking about?...Uh huh. What did she want?
A. She wanted a bright, intelligent strong boy…..she wanted somebody who she could present as the perfect child…who she could exhibit…who she could boast about I suppose…and I just did not fit that bill.
K. And she wanted that child….that strong, perfect child she could boast about to be a boy?...Mmm……and you feel shameful that you didn't fit the bill?
A. I can remember as a child…. desperately feeling…I can't be what she wants. No matter how hard I try I can't be bright, intelligent….
K. Mmm….A do you still feel a sense of shame that you didn't match up to her requirements?
A. It still sits there.
K. Your mother was a monster A……..(silence)…..can you hear that?...She was a monster.
A. As a child she was my mother.
K. I know that. I'm asking….hence I ask about that sense of shame now…she did monstrous things to you…she colluded in the horrendous abuse.
(Tape32)

Looking back now at this tape, it still has the power to make me squirm. I can still sense the effort I used to put into trying to please my mother and would do all sorts of things to try and compensate for her disappointment in me. (see table 4) Listening too to my voice when working through this with **K** I can 'hear' the shame of even talking about it. **K**'s voice is soft in response which although helps does not eradicate the whole feeling of shame.

Listening to most of the tapes brings about an enormous sense of shame: shame that what happened, happened at all – and to me; the shame of not doing something about it at the time, of not telling anyone and thereby in some way colluding with my abusers; the telling of the story to **K** and revealing all the abhorrent details; the shame of dissociating.(see table 4) Even writing this research elicits a huge sense of shame and right throughout the process I have questioned whether I have the right to do it - a consequence of being shamed, and how I will be viewed - a consequence of being exposed! (see table 4) Should I continue to hide my past? It was Wiesel, (2002) talking of his experiences, who spurred me on.

And yet……

> "The man writing these lines must be frank: he doesn't want to tell you about this uniquely bloody and murderous period; he's reluctant to talk about his past. What can he achieve by making you sad? Why keep denouncing the indifference of some and the collaboration of others? And why bring up his own past when millions of other human beings have suffered as much as – if not more than – he has? The survivor must be a witness. (my highlight) He doesn't have the right to hide behind a façade of false modesty. The easy way would be to say nothing…….So listen."
>
> (p9)

Tape 6 opens with an enormous air of shame. I only wish there was some way of portraying voice on paper. So much is lost in the transcribing. McGuiness (2001) posits the question of how you quantify pain; I ask the question of shame.

K So….have you managed to listen to last weeks?....How did you respond?
A. It's still hard listening to….me that's not me…(reference to listening to the personalities)…Does that make sense?...Um…I actually find some of them embarrassing…
K. Uh huh…What kind of embarrassing A?....(silence)….
A. Because I don't know…because I have no..um…because I have absolutely no recall…I know…and I know we've said this before…I know you know you can tell me…but hearing it and having absolutely no recollection of it…um…of having no control …it…it….have no control over obviously what whoever it is, is saying…..um…it's a horrible feeling …It's like…it's my voice but it's like listening to somebody else.

K. Mmm….mmm…It sounds like there is …is a disconnectedness.
A. I suppose it is someone else really…..but it isn't…..I'm just thankful it's not videoed.
K. Uh huh…..What difference would video make A?...
A. Well I'm shocked at what I hear….God knows what you must see!
K. What do you think I see A?...(long silence)….
A. (softly spoken)….It doesn't bear thinking about.
K. Uh huh….(silence)….. (Tape 7)

There is a shame here of even dissociating. Reading it now I have a sense of cowardice both for dissociating and for what is 'my' history. (see table 4)

The conversation continues around how sometimes it is difficult to recall in conscious memory what the personalities have revealed and that how sometimes the difficulty lies in perhaps not wanting to know or own the memories.

A. Because I think sometimes …those are the times when there is something…there is something that doesn't want to …doesn't want to connect.
K. No.
A. I don't want that as my history…..(quietly said)
K. No…..no….(silence)…..So you don't want to own that?.....no. (Tape 7)

I begin then to relate a conversation that I had had during that week with friends when

we were sharing childhood memories

A. … they always knew they were there for each other…how…They painted this sort of idyllic childhood….(silence)…and um….so I kept quiet…all the time I was listening to them…I know it was very selfish but I just thought …it's not fair…and I couldn't understand why….(silence)…and I listen to those tapes and I think God why?
K. Mmm….mmm….(silence)…..Why did your life have to be so….so horribly different…because it seems to me that what they were sharing was in a sense nothing extra special. They were just sharing ordinary family life….every day family life for many people….You were denied even that A….You were denied even ordinary family life …let alone anything special….Yeah. It's not fair….(long silence) ….
A. And one of them …um…um…you know, started to ask questions …and I tended to give them facts rather than….because they were all Northerners and I just said "Oh

well I lived down South just an only….but it was just facts….and I just sort of said well I don't really remember very much…. laughed it off by saying it was such a long time ago.

A little further on….

A. Part of me was sitting there thinking I wonder if you would sit and talk to me if you knew?
K.Uh huh…and how do you answer that question A?....
A. Well it would be a bloody conversation stopper…
K. Do you think they would talk to you?
A. No.

And a little further….

A. I think about everything that has happened….particularly that….and I… I feel this it's like a physical heat…the only way I can describe it is if ….you're going through the change and you have one of these awful hot flushes…and that's how it feels. It just swamps ….um …you know….you're….
K. You've got to make 'I' statements about this because it's not connected with me at all! A Yeah and that's not fair either!....
A. You just think that they can see….
K. Uh huh…Who can see?
A. It comes over like a wave….and um….it's like a you know…..as I said it's a bit like a hot…when somebody has a hot flush you can tell…um they go bright red and that's how it feels…and it feels as though people can actually s…. see ….
K. See what A?...(silence)….
A. The shame of it all…(quietly said)

K. Mmm…(long silence)….Mm…so you think that people can see the shame of it in you just by looking at you…and if only they knew what you were ashamed about then they wouldn't stay with you …….(long silence)……

(Tape 7)

At this point it becomes too hard to handle and **Susie** takes over.

K. What's happening now A?...(silence)…Who are you?

Even writing this now I am asking myself the question "What am I doing in bringing this to a public forum?" Just recalling this passage has brought quite severe physiological reactions and I have managed to bite my carefully grown nails right

down which for me shows the pervading influence shame can have. The shame of the past still has the power to impact on my present life. I feel that I have been, to coin a new word, 'enshamed' by 'my' life's circumstances and that the only way to receive some kind of respite from this was to dissociate. The task of therapy here is to perhaps relocate the shame and liberate my conscience.

The sense of shame seems to have reached into the personalities. It isn't always what they say so much as how they say it and this is difficult to show when transcribing texts. **Simon** stutters when talking and this seems to be both because of the nature of what he is revealing and his response to it. It can be difficult to distinguish sometimes between fear and shame. 'I' pick up on the silences and the voice inflections and make 'my' own deductions but I have to concede 'I' am not him. **Helen** and **Susie** both drop their voices into a whisper at times which feels as though they are ashamed of what they are feeling or saying. Shame pervades 'my' subconscious and even displays itself in the alters. (see table 4)

Tape 24 seems to me to shout out shame. **Susie** relates a couple of incidents that have happened and her hushed tones speak strongly of her sense of shame. Here she is talking about one of the nuns who taught her at school. She has been punished for some misdemeanour and had to write lines.

S. I have to write them out two hundred times in my best handwriting.
K. And you don't know what it means…that sounds like they are being stupid to me…the teacher who`s making you do that sounds like a …stupid to me.
S. Sister I. M.
K. I don't think I like Sister I. M.
S. You wouldn't like Sister I.M…..(very hushed voice)……..Hurt feelings are an indulgence in self-love.

(Tape24)

Susie does not understand the meaning of the lines she has to write and **K** carefully explains what the words mean. She goes on to admit in very hushed tones that that this teacher does not like her.

S. She doesn't like me.

Her sense of shame at not being liked can be powerfully felt listening to her hushed and embarrassed tones.

K's understanding and validation of her encourages her to be even more open about her feelings towards this nun. Her voice is very quiet and **K** has difficulty hearing her.

S. Sister I.M. is nasty.
K. Say that again please.
S. Sister I.M. is nasty.
K. She's nasty is she?....(silence)….So I definitely wouldn't like her?...Mm?
S. It's cos I can't draw.
K. You can't draw….Are you sure….Who says you can't draw?....Sister I. M. says you can't draw.
S. I'm rubbish.
K. Your rubbish….At drawing?
S. I'm rubbish anyway.
K. Your rubbish anyway?....Who said you were rubbish anyway?....(silence)….Mmm?...Who says you are rubbish anyway?
S. Mummy.

(Tape 24)

The tone of voice that this conversation is spoken in suggests strongly a real sense of **Susie**'s shame and is reinforced for her because the opinion that is being expressed about her is that of two people. There seems to be a double sense of shame that not

only can she not draw and therefore is inadequate in that field but she is inadequate in general – "rubbish anyway".

Later in the same session **Susie** expresses her real feelings towards her mother with a real deep sense of shame - a shame that seems to have been inculcated by her religious upbringing.

K. Your mother wasn't a very nice person.
S. Shhhh.
K. She won't hear. Your mother wasn't a very nice woman Susie…um…that's my opinion….
S. Everybody likes her.
K. Everybody likes her…..Do you like her?...(silence)….Mmm?
S. I have to like her.
K. Oh….I didn't say you have to like her. I said do you like her?
S. You won't tell?
K. I won't tell.
S. But it's wicked.
K. What is?
S. Not liking your mum.
K. Uh huh…Who says?... I like my mum because my mum was a nice person…she was a lovely little woman…she's dead now…..She was very nice and I liked her. I don't think I like your mum….
S. I don't like her…(spoken quietly)

K. You don't like her…OK….You don't have to whisper. You can say it, that you don't like your mum.
S. But it's wrong
K. Is it?...Who says…(voice indignant)..
S. I have to honour and obey….
K. Ohhhhhh!!... (sound of exasperation)…
S. …and be nice and good….I hate her.
K…(laughs)….you hate your mother….Right..You hate her.
S. I told the priest in confession once that I hated her.
K. Uh huh…and what did he say.
S. I got into trouble…..(voice very quiet)
K. Pardon?
S. I got into trouble….He told me it was so wrong (Tape 24)

The tapes are littered with silences which are often acutely painful and embarrassing.

K. Mmm….because they were calling you ugly on the outside therefore you must be ugly from the inside….Do you regard yourself as ugly now?
A. Mmm…..(embarrassed silence)…… (Tape 34)

While trying to illustrate the felt sense of shame that permeates the tapes I began to realise how invaluable videoing the sessions would have been. Hindsight is a wonderful teacher! However I do recognise that there would have been enormous practical and possibly even ethical problems here. And I'm not sure the personalities would have allowed this. Some may have been comfortable with this and others not and there is no way of knowing who would present themselves in any given session.

Examples of evidence of a sense of shame.

Sense of shame present in	Examples	Ultimate Effects
Silence in childhood The need to hide the truth - secrecy	Failure to reveal/report abuse Keeping up a 'front' to outside world Going against innate code of ethics	Continued silence in adulthood Loss of memories Dissociation Isolation Dissociation Fear Self loathing
Use of language towards self Use of language in DID	Abusers constant 'putdowns' and criticisms Use of term "disorder" in DID	Sense of being defective Self blame Sense of failure Effect on behaviour patterns
Expectations of others	Mother's desire for a boy School achievements How 'I' performed for abusers	Low self-esteem Sense of inadequacy at core of self Sense of failure Sense of not belonging A need to please Attempt at suicide. Dissociation
Expectations of self	Failure to live up to others expectations. Desire to be 'normal' Few ambitions or vision of the future	Low sense of self worth Isolation Sense of failure Loss of hope Disenchantment Attempt at suicide
Sexual Abuse Physical abuse Psychological abuse	The acts of abuse and perversion Physical brutality Neglect Realisation that it was not happening to others around me	Feeling dirty/violated Sense of worthlessness Loss of control of own life Guilt Self disgust and loathing Belief that 'I' cannot be loved Internalisation of shame Bad decision making in adulthood Fear Dissociation Disenchantment with life
Religious teachings and upbringing.	Experience of education in Convent School Enforcement of Catholic dogma e.g. the commandments Rules of religion	Fear of 'God' Fear of sin and its consequences Confusion Sense of unimportance Compliance Fear of the future and death Religious control
Disenchantment	Life outside own control Reality too hard to bear	Sense of inadequacy/weakness
Dissociation	The need for alters to cope with events and emotions	Sense of cowardice
Revelation Fear of disclosure	Failure to tell anyone in childhood Giving of abuse details in therapy Writing this research	Denial of truth to self Sense of collusion Dissociation Self loathing Fear of rejection and abandonment Fear of not being believed Fear of judgment Body language – no eye contact, head down
The Alters	Simon stutters Others often talk in whispers	Dissociation is a means to avoid/escape emotion
Inability to talk about shame	Avoidance of overtly alluding to shame. Other words/phrases used e.g. "I hate myself"	Inability to process new information.
Anger/Rage	Inability to talk about anger and shame Presence of Leah Destructive thoughts of self. Disclosure of past events	Inability to process new information Opening for self destructive behaviour

Table 4. Basis for theme of: shame

6.1. Discussion.

"She had a new feeling, the feeling of danger; on which a new remedy rose to meet it.
the idea of an inner self or, in other words, of concealment."
Henry James, 'What Maisie Knew'

The word shame is derived from the Germanic root skam/skem, with the meaning "sense of shame", being shamed, disgrace. It can be traced back to the Indo-European root kam/kem: "to cover, to veil, to hide". The prefixed s (skam) adds the reflexive meaning - "to cover oneself" The notion of hiding is intrinsic to and inseparable from the concept of shame (Wurmser. 1981).

Shame by its very nature demands secrecy and diversions. Dissociation fulfils both. It ensures that something remains both out of the public eye and out of consciousness and at the same time creates a diversion from what is going on. Compared with its companion guilt, shame has been an affect vastly underestimated in literature, supervision and discussion. Looking through the vast amount of theory and literature written about abuse and DID I was surprised and disappointed that the emotion of shame, although usually acknowledged, was given little or no space for exploration. I was left asking the question "Why is shame not given the same time and exploration as other emotions when dealing with abuse and DID?" It seems to be bypassed. I can only think that as therapists we sometimes want to make everything better for our clients and shame is difficult to 'cure'. Also when listening to the shame of our clients it can tap into our own and if we are uncomfortable with our own shame we may then avoid the shame of others.

Wurmser (1981), when working with his client base (schizophrenics, criminals), felt "stymied" when dealing with their shame.

"Sometimes stacks of references led me to mere sterile scholasticism, and at other times, while trying to recast the conceptual framework, I felt tempted to see almost everything in the light of shame and to revise in wild temerity even solidly built and useful theory"

(p6)

I too felt "stymied" when acknowledging my overwhelming sense of shame and the effect of finding little discussion of this in connection with DID and abuse left me feeling on the one hand marginalised further from those who have had these experiences and to follow Wurmser in the temptation to revise "even solidly built and useful theory". Neither of which in reality is useful. What seemed important was accepting the fact that shame was still playing such an important and dominant role in my life and acknowledging that even though the events that caused the shame are past the experience of shame is one that stills burns deeply within. It is hard to define shame scholastically without it triggering the emotion itself.

Underwood-Rosow (1996) writes

"It is foolish to expect a person experiencing shame to remember anything said to him or her. Talking to a person experiencing shame is like talking to a drunk"

(p19)

People are unable to process new information while they are experiencing shame (Underwood-Rosow 1996) I hadn't been fully aware of this until doing this study when realising that visiting and revisiting sessions through the tapes was giving me further opportunity to assimilate material and to face and accept fact and shameful

emotions often months and years after a session, something I couldn't obviously do at the time. However I now recognise this as a deep sense of shame even though I don't think I was actually consciously aware of this shame at the time. I just knew I didn't want to face things. (see table 4) I was able to share this with K in a particularly painful session but in a round about way not still being able to label the feeling out right!

A. It's actually very painful going back and listening to a tape….I seem to be able to listen to a tape after a session….do what I have to do with it and put it away……um….but having to go over it (reference here to studying the tapes for this research) and look at it….feels a lot more painful now than it did then…
K. Really
A. …if that makes any sense….now I don't know what that's saying…..
K. Right…(long silence)….
A. But what I have noticed is that there is very little difference between….for me now…..whether it would have been different for me as a child…because 'I' didn't do the feelings then….that's what I find difficult…but for me now there is very little difference between feeling fear, anger and shame…..they kind of role into one….

(Triangulation tape.Tape 140)

I am beginning to acknowledge here that I did what I thought was necessary with the tapes but avoided looking at them too closely because they were making me feel more than uncomfortable. I had in the past acknowledged embarrassment at listening to them at times.

A. It's still hard listening to….me that's not me…does that make sense?...I actually find some of them embarrassing……..I am shocked at what I hear…God knows what you must see!

(Tape 8)

A little further on in triangulation tape 140,

A. …but going back over the tapes ……is a lot harder than I thought it was going to be.
K. Mmm.

A. I thought like everything else I could detach from it…..which has been second nature to me all my life to actually detach from stuff…
K. Mmm.
A. ..um….but it….sounds a bit daft this….but it's like reading the Bible…every time you read it you read something different….or you interpret something different…
K. Mm…yes.
A. …and it's like listening to those tapes….the more I listen to the tapes the more I hear in them….and….I've come to the conclusion that when I actually go away and listen to them…take it away and first listen to it….I'm not hearing it…..with full ears.
K. Mmm….(silence)…
A. It's only when I put a bit of distance between it……between listening to it and then going back and listening to it again that I actually seem to hear it properly.
K. Yes you need that time, that space…
A. Yeah. Does that make sense?
K. Oh yes. Of course it does.
A. So going back and listening to those tapes is horrendous.
K. It sounds as if it takes a lot out of you.
A. Yes. It does…..and then to actually put it on paper…….(long embarrassed silence)…I didn't realise what an ordeal it was going to be to be honest.

I can visualise myself in this session feeling very uncomfortable. I was finding it extremely difficult to talk and to get round to telling **K** outright my deep sense of shame. It felt so terribly risky and even writing this now 'I' feel an intense sense of shame which is manifesting itself in rapid heart beat, sweating and blushing, a re-enactment of how I was feeling in the session.

K delves a little further.

K. So what is it about putting it on paper A....that sounds like….it has a difficulty all of its own?
A. Almost because it's ……(sigh)…..it's almost like setting it in stone……um…..(silence)….and when you put something on paper it's done with the intent of someone else to view it….(silence)…
K. Mmm….it's almost become public.
A. (softly)….Yeah and that actually is quite frightening. (tape 140)

In effect what I am contemplating here is making my 'shame' public which is something which we tend not to do with shame. Shame is something we want to conceal; we fear exposure (Underland-Rosow 1996). This is something I would challenge the opponents of DID with when they say that those who present with dissociative tendencies are attention seeking (Spanos 1985). It is not a condition a client openly displays but often carefully endeavours to conceal it. (Bliss1986: Ross 1989). My experience is that shame is a powerful reason to conceal! There is a huge risk in revealing one's shame. How it is received is crucial. If there is acceptance and sensitivity then there is a chance that shame can be dissipated. If it is received with condemnation or judgement then there is a chance of reinforcing it which can compound and deepen the shame, maybe beyond restoration.

6.2 Shame Historically.

Shame is a tool of control and is insidious. We encounter it in all walks of life. It can be a complex and cognitive reaction.

Berman (1989) talks of his belief in "disenchantment" which he sees as a disconnection, a separation into observer and that which is observed or object. He sees disenchantment as a lack of participation in one's own life and environment. He hypothesised that gradual disenchantment began 4000 years ago and culminated with the rise of Newtonian science believing that before Newton we lived in an "enchanted" world. Underwood-Rosow (1996) takes this a step further believing that disenchantment was a major factor in the development of shame. She sees that with disenchantment came the belief in a need for an outside influence to "guarantee conformity and compliance". (see table 4)

"This force, embedded throughout our society is shame. Shame occurs in the presence of disenchantment and is deemed necessary when humans experience disenchantment. When there is no division, no disenchantment, the possibility of feeling defective to the core is virtually eliminated. If a person is one with the universe, he or she cannot conceive of himself/herself as defective. If people live in partnership, at one with one another, the need to control is not an issue: therefore, shame serves no purpose." (p36)

I can identify with the feeling of disenchantment and development into shame. Perhaps this sense of "disenchantment" was contributory to 'my' dissociation. Life in reality became hard to bear at an early age and I sought refuge in books and in solitude. As I have said I learned to read at a young age and spent many hours in my room 'entering' the stories I was reading to give relief from reality. I soon learned that there was no-one to turn to and reached a point where I gave up hoping for rescue. I even stopped praying to God. (see table 4) The disenchantment soon turned to a sense of shame when realising that there was no-one who would help not even God which in itself was the ultimate rejection and therefore the ultimate shame. This only reinforced a dawning sense that there must be something defective in me. Dissociation was the next step, to move away from the overwhelming sense of shame and disenchantment. (see table 4) What I did not realise then was that whilst it gave immediate relief it only later reinforced my sense of shame when I realised that no-one else dissociated around me and also when I began to see dissociation as a coward's way out! My shame became internalised. (see table 4) When shame becomes internalised it stops functioning in the manner of an emotion and becomes a "characterological style" (Bradshaw 1988). It becomes an identity. A constant feeling of shame can be too much to cope with and we know how many suicides are committed because of shame. I made three attempts in my early life. (see table 4)

It seems that shame's major function throughout history has been to control. As nations have fought and conquered nations, shame has been used by powers to dominate. We see throughout the centuries how invaders used physical and emotional reprisals, how they eliminated cultural heritages and destroyed sacred and religious places and beliefs. How common was it for the dominating conqueror to judge the vanquished as defective should they not conform? The experience of being judged as defective results in the judged feeling shamed. (see table 4) When doing my MA one of the outcomes was around the use of language when talking about abuse and DID and how words can be interpreted. The use of language can shame. (see table 4) The act of judging people as defective can result is a sense of shame for those being judged. It seems to me the term 'disorder' in Dissociative Identity Disorder has a shaming affect. It is a judgement. Disorder, or dis-order suggests defect, something not perfect, or something not acceptable - something to be changed or 'cured' – something to be ashamed of. (see table 4) I am more comfortable with the term Dissociative Identity Existence.

The Judeo-Christian tradition introduces the notion of shame from its very beginning. One of the most important myths in this culture dealing with shame is the story of Adam and Eve in the Bible (Gen.3:1-24) a report that can be dated around the tenth or ninth century BC. In this paradise narrative, feelings of guilt and shame are depicted as showing acts of disobedience to God who had forbidden humans to eat from the Tree of Knowledge. Until then the text explains that "…both of them were naked, the man and his wife, but they felt no shame before each other." (Gen.2:23). Once they had disobeyed God, Adam and Eve felt different. "Then the eyes of both of them were opened and they realised that they were naked. So they sewed fig leaves together to

make themselves loin cloths. (Gen. 3:7). It was Adam's nakedness that exposed his violation of God's trust; it was proof he had eaten from the Tree of Knowledge. This seems to tie in with Berman's (1989) theory of disenchantment.

Other cultures also talk of momentous loss through human violation. There are many African myths that depict this and Greek mythology tells of how the Golden Age was lost by human fault. Often humans stole something from the gods such as Prometheus's theft of fire. The Bible suggests the same of Adam and Eve. " Now that man has become like one of us in knowing good from evil, he must not be allowed to reach out his hand and pick from the tree of life too, and eat and live for ever" (Gen.3:22). What follows is punishment reinforcing shame. "So Yahweh God expelled him from the garden of Eden, to till the soil from which he had taken. He banished the man, and in front of the Garden of Eden he posted the great winged creatures and the fiery flashing sword, to guard the way to the tree of life" (Gen. 3:24).

To disobey was not in my vocabulary as a child. Apart from the fact it wrought such retribution, it was something that as Catholics we were taught as commandment "Honour thy father and thy mother". To break the commandments was to sin. The result was compliance and a desire to please – or perhaps it was fear of the consequences. (see table 4) The personalities often talk of their religious teachings and how they affected their behaviour and responses to their abuse. **Susie** in particular would often exasperate **K**.

S. I have to honour and obey……
K. Ohhhhh!....(sounds of exasperation)…

S. …and be nice and good. (Tape 24)

To go against this felt too shameful even though at times to obey felt innately wrong. It felt confusing. It was a case of being 'damned if you do and damned if you don't'. There was shame in disobeying and shame in obeying and if I was to tell there would be shame in the revealing. (see table 4) Is it any wonder that I became 'enshamed'? In order to disown 'my' own shame I found a way out – dissociation.

There are incidences in the Bible that reinforce a child's sense of unimportance. We see Abraham's obedience to God and Isaac's to Abraham, to sacrifice a child. There is the report of the slaughter of all the firstborn of Egypt. These stories told to a child insecure in an adult world reinforce her sense of shame - shame at not reaching expectations and therefore only fit to sacrifice. I never felt I measured up and so often felt grateful just to be allowed to live.

A. One of the things that sat so strongly with me…one of the things I've never really forgotten was…my sense of shame at not being what my mother wanted…not reaching her ambitions for what a …her child should be….not…not...not being who she wanted……I can remember as a child ….desperately feeling ….I can't be what she wants…
K. Mmm. Do you still feel a sense of shame that you didn't match up to her requirements?
A. It still sits here.
K. Your mother was a monster A!....Can you hear that? She was a monster. (Tape 32)

But you see monsters were accepted and even revered in the Bible and therefore in the eyes of God.

6.3. Systems that promote shame.

Shame is an isolating experience but does not happen in isolation. (Underwood-Rosow 1996) .There are systems and entities which contribute to and reinforce the use of shame to gain compliance.

We have seen how the Garden of Eden story makes clear that shame has been used to control mankind since at least the beginning of Biblical times. Christianity has gone on to use shame as a controlling mechanism. (see table 4) Missionaries 'accused' those they were trying to convert of being "heathens" and that their only salvation was through Christ. This was the Christ who is centred as the redeemer but who was profoundly degraded and humiliated both during his life and in his death. I sense the Church has interpreted this to mean that virtue is in subservience, obedience and in the abdication of autonomous thoughts. It seems to me the Church sees it as our duty to bear the cross of submission while attributing doubt, questions and rebellion to the devil and his works. Alice Miller (1997) writing about the Auschwitz commandant Rudolf Hoss takes a quote from his book Der Kommandant von Auschwitz. She says

> "...Rudolf Hoss has, for instance, tellingly characterised his childhood - albeit without perceiving in it the roots of his inhumanity – Above all, I was constantly reminded that I was to comply with, and follow the wishes or commands of parents, teachers, priests, etc., indeed all grown-ups including the servants, and that I was to allow nothing to distract me from that duty. Whatever they said, went. These fundamental values of my upbringing became part of my flesh and blood."
>
> (p78)

Does an abused child stand a chance in this environment? How often were we taught to 'turn the other cheek'? And, if Christ could bear his cross for me then surely I should do it for him?

As a child I can remember the humiliation of going to confession every Saturday morning, to admit my wrong doings to a man whom I saw on a regular basis. This was indeed hard enough but on the one occasion when I tried to talk about what was happening to me I was accused of being fanciful and told what a bad child I was for

making up these stories about pillars of the community. I was refused absolution and told to go away and "think" about what 'I' had just done. Susie also recalls an incident in confession.

S. I told the priest in confession once I hated her.
K. Uh huh. What did he say?
S. I got into trouble.
K. Pardon?
S. I got into trouble…He told me it was so wrong. (Tape 24)

However, it is not only in religion where we experience shameful events. Our school years can so often be shaming experiences. Shaming is often a way of controlling students. Being made to stand in a corner with your back to the class can leave a child exposed and humiliated. My experience in teaching has shown that the fear of making a mistake and being laughed at so often stops children from answering questions and the fear of being the last to be picked for a team can bring anxiety and embarrassment to the child who does not excel at sport.

Following a night of abuse there were times when I could not sit down at school and was seen as disobedience or me being difficult when I would sit kneeling on my legs on my chair and refuse to do otherwise. If it was too painful I would risk the humiliation of being made to stand in the corner. This brought huge distress as I felt everyone could see what the matter was. It just seemed that one incidence of shame would feed into another. Underwood-Rosow (1996) found when looking at shame in education, that

> "Poor students are often shamed for doing poorly, but excellent students often feel shame as well." (p97)

My experience sits well with this. No matter how hard I tried it would not be good enough and even when I did shine at something there was someone to put me down. (see table 4) I was given a major part in a junior school production and the play had been well received by the audience. Afterwards one of my abusers who were present at the production took the shine out of the event for me. I was left humiliated and ashamed following this incident

A I was standing there pleased as punch Because it had been received very well.
K. Uh huh. Still with your blackened face?
A. Yeah. My uncle was looking at V and looking at me and saying "Well you can tell why she got the part…um…they couldn't give her anything else. At least they could hide her face.
K. ….. God they cut you to pieces didn't they….without even laying a finger on you.
(Tape 34)

We can find shame used to control in almost all walks of life, in politics in the past with slave labour and today in Third World countries where there is cheap labour. We see it in the media and advertising where guilt and shame are almost promoted to get us to 'buy' the latest model or 'aspire' to the latest style. We can see it in our parenting. A child feels shame when s/he is rebuked or chastised in front of other people.

6.4 How shame functions.

Shame like guilt is an unpleasant emotion experienced as if it were directed by one agency of the self against another.

"Whereas guilt refers to punishment for wrongdoing, for violation of some rule or internal law, shame is about some quality of the self. Guilt implies action, while

shame implies that some quality of the self has been brought into question. (Lewis,1971;Wurmser,1981).Experience teaches us that wrongdoing may be punished by guilt; while unwarranted opinions about self, when exposed, will be punished by shame." (Nathanson 1987)

Nathanson (1987) describes shame as a response to exposure. He says that by forcing attention to the self it protects us from narcissism, "…as when we are made to accept that the viewing other does not share our opinion of ourselves." (p5).

Many other writers such as Lynd 1958; Wurmser 1981) agree that shame follows a moment of exposure and that this uncovering reveals aspects of the self of a sensitive, intimate and vulnerable nature.

In 1981 Wurmser summarized the content of shame saying that what one is ashamed about or for clusters around several issues;

1) I am weak, I am failing in competition.

2) I am dirty, messy; the content of my self is looked at with disdain and disgust.

3) I am defective; I have shortcomings in physical and mental makeup

4) I have lost control over my bodily functions and my feelings

5) Watching and self exposing are dangerous activities and may be punished.

6) I am sexually excited about suffering, degradation and distress.

Kaufman (1985) adds to this noting that the shame is an experience in which we feel torn from our fellow human beings. Betrayal, treachery and abandonment, he says, can induce shame. It can also lead to a sense of isolation. (see table 4)

My own experience bears out the observances of both Wurmser and Kaufman. I can identify with the first five points of Wurmser's content of shame. My sense of betrayal and abandonment by both my fellow humans and by God confirmed my worthlessness and served to enshroud my shame – 'enshaming' me.

I would take one thing to task here. Exposure is not a necessity in order to feel shame. The secrecy of abuse often prevents exposure but the sense of shame is there. The knowledge that what was happening to me was not happening to my friends led me to keep the secret even more hidden to prevent the exposure and therefore the public humiliation. However the sense of shame was intense and the fear that others would find out and despise me was phenomenal. The fear of further abandonment was paradoxical as I already felt abandoned in that no-one was protecting me. My religious teachings told me that what was happening was a sin and the deep sense of shame that this was happening was not helped by the thoughts that I was doing nothing about it. My exposure was in the fear that God 'knew' what was happening and his would be the ultimate abandonment. After all he did not come to my aid. My shame felt in secrecy was in that what was happening was against my innate code of ethics. To go against one's code of ethics is probably one of the biggest causes of stress and shame. The result was a hatred of self. (see table 4) Where that innate ethical code came from I am not sure. Because I was abused from an early age, I do not have any lived experience about life before abuse to make a decision as to whether abuse is right or wrong. Perhaps it is in part genetic or evolutionary.

Lewis (1981) states that the human is social from birth and that both guilt and shame are affects that serve to mend affectionate bonds and that they are "inherently" social affects. She goes further to suggest that the blush evolved to inform the viewing other that we wish to be accepted back into human society.

Tomkins(1992) when studying the facial expressions of his newborn son, noted that this infant was displaying all the facial expressions of emotion without the history. none of the life experience we have always considered necessary for the development of emotion

"Certainly the infant who emits his birth cry upon exit from the birth canal has not appraised the new environment as a vale of tears before he cries" (p362)

He notes that the crying infant looks like a crying adult. He attributes this cry of distress as having been 'available' to the baby courtesy of some pre-existing mechanism triggered by some stimulus acceptable to that mechanism. Tomkins postulates nine mechanisms, a group of primarily facial responses that he calls "innate affects" as operating from birth. He gives each of the innate affects a two word group name e.g. interest – excitement; surprise – startle; fear - terror; anger – rage. The first word indicates the mildest form and the second word indicates the most extreme. Each affect is characterised by facial expression e.g. anger – rage is characterised with a frown, clenched jaw, and a red face; fear – terror with the eyes held open or frozen in a fixed stare. Shame – humiliation is shown with the eyes and head lowered. The first seven of the nine mechanisms are not intrinsically connected to any form of drive. The remaining two Tomkins calls "drive auxilaries" or mechanisms that interact with the specific drive hunger. They are taste and smell.

My interest here of course is in the shame – humiliation affect. As we grow older we exhibit a complex combination of learned display of affect patterns with true innate affect. It is the quickness with which the baby assumes control over the muscular activities in its face that led Tomkins to believe that researchers have ignored the face in the past. I have no memory or witness to how I responded as a baby. However, now

as an adult, I still cannot give **K** eye contact in our sessions and often hold my head in a downward position.

Tomkins (1992) says that the face is the primary site of action of affect. **K** has often commented on how he has read fear in my face. However I learned from a young age to hide my emotions for fear of the consequences of revealing them. I learned to keep a very deadpan face. Basch (1976) suggests the use of the term "affect" to refer to biological events, "feeling" to indicate awareness of the affect and "emotion" as the combination of an affect with previous experiences of that affect. Here I ponder the question that once the 'affect' is in consciousness (i.e. the biological event of abuse) was dissociation a guard against the response of feeling and emotion and therefore a protection from perceived consequences of expressing these?

> "The experience of incest with its predominant message that love equals abuse has great potential to undermine a positive identity. The experience of abuse enters the self-concept; a significant number of incestuously abused children come to believe that something about them, something inherently wrong with them, caused the incest to occur. These beliefs, coupled with guilt and anxiety, result in a shamed sense of self – that the self is unlovable, deserving of abuse, and unworthy of care and good attention. In addition children incorporate a sense of stigma from having been involved in a secret and forbidden activity, something so awful that it could not be discussed."
>
> (Courtois,1996)

For many years and well into therapy 'I' believed that there was something inherently wrong with me. Even now there are times when I will still question it. It led to self-hatred and a negative sense of self-esteem and a denial of rights. (see table 4) There was this sense that if my parents couldn't love me then who could? This was reinforced all the more as I was adopted. That was two sets of parents who couldn't love me. The shame effect was an essential part of how I viewed and entered into

relationships throughout life, from forming schoolgirl friendships to possible romantic liaisons to relationships with colleagues, neighbours and friends in adulthood.

6.4.1 Shame – humility

As we have seen in the previous section Tomkins (1992) linked shame and humiliation as one of the "innate affects". He sees the trigger to shame affect as being any experience which requires a quick decrease in the affects of interest – excitement and enjoyment – joy in the infant or adult who wishes to stay with the pre-existing affect state. "innate affect" mechanisms.

Bradshaw (1988) describes shame as having pre-verbal origins and defines it as being either "nourishing shame or toxic/life-destroying shame".

"As toxic shame, it is an excruciatingly internal experience of unexpected exposure. It is a deep cut felt primarily from the inside. It divides us from ourselves and from others. In toxic shame, we disown ourselves. And this disowning demands a cover up.
(p3)

"In fact a toxically shamed person has an adversarial relationship with himself. Toxic. Shame – the shame that binds us – is the basis for both neurotic and character disordered syndromes of behaviour."
(p10)

I can identify with Bradshaw's theory. The need to disown self and 'cover up' became a fixation. I did not want what was happening to be a part of 'me' or my life but it was, so the next best thing was to conceal it at all costs. Dissociation and the development of 'others' was a good way to do this. However, instead of solving the situation and the feeling of shame it only compounded it. I felt 'ashamed' of not facing what was happening and doing something about it and thought others would see it as a cowardly way out. (see table 4) It felt a viscous circle. I was using shame to hide shame. This was carried into therapy when my fear that **K** would recognise that

what happened to me did so because of something about me took hold. It took years of patience and understanding on his side to reassure me that he would not use what I had revealed to him as an excuse to finish our therapeutic alliance. It was a cause of great anxiety and if I'm honest still sometimes raises its head!

Bradshaw (1988) posits that "healthy shame" gives us a permission to be human. It is the "psychological ground of our humility" and is essential as the "ground of our spirituality" (p9) He says

> "Healthy shame….is a yellow light warning us that we are essentially limited. Healthy shame is the basic metaphysical boundary for human beings. It is the emotional energy which signals us that we are not God – that we have made and will make mistakes, that we need help. Healthy shame gives us permission to be human." (p4)

He explains that he sees spirituality as being to do with our life-style which is ever unfolding and growing and so is about expansion. It incorporates such experiences as love, truth, goodness, compassion and caring and beauty among others which move us towards a wholeness and completion. He sees this as our pathway to transcending ourselves and to becoming "grounded in the ultimate source of reality" Many will describe that as - God. He feels too that healthy shame is essential as the ground of our spirituality. It shows us our limitations and lets us know we are not God.

While I think I understand Bradshaw's line of thought, that a little shame is good as it informs us we may have transgressed and therefore need to make some kind of reparation, I have to agree with Underlan-Rosow (1996) who feels he may be confusing spirituality with religion. She argues that shame is the "psychological foundation of many religions" and is "antithetical to spirituality". She sees that

whereas much of our institutional religion separates us as humans from our feelings, thoughts and desires as well as from each other and a Higher Being/Power, spirituality "brings things together." Spirituality is about connectedness, about oneness with the universe. It doesn't seem to judge us and place us on a 'conscience blacklist' as religion feels to do, but seems to be allowing me to be a part of it warts and all.

Shame by its very nature involves disconnection, alienation and separation and most of our Western religions seem to demand separation and shame. When I try to see myself as Catholic or Christian I am 'ashamed' of my 'transgressions' and feel, to coin a new word, 'enshamed' by my life's happenings. I feel separated from those around me, different, sitting on the fence, watching, unworthy to be a part of. If I look at my life in a more spiritual sense, rather than a religious one, I do not feel so disconnected. I suppose what I am experiencing here is what Bradshaw (1988) describes as shame being transformed into an identity and once this happens it becomes toxic. But, as Underwood-Rosow (1996) points out, shame is always internalised and therefore is always toxic. Perhaps, as Underlan-Rosow (1996) suggests, Bradshaw (1988) is confusing "healthy shame" with humility. Her argument lies in Bradshaw's line that "healthy shame" is the "psychological ground" for humility. It seems to me that it is humility that motivates people to change not shame. In coming into therapy it is a sense of humility that is motivating me to make changes but it is the sense of shame that is hindering the process. As Underland-Rosow (1996) comments,

> "...healthy shame - is actually the humbling of the spirit. But humbling does not involve the same dynamic as shame. Humbling means honest recognition of self. Shame doesn't allow for that connection, that recognition."
>
> (p53)

If we look at the 12 –Step programme of Alcoholics Anonymous humility is their fourth step.

"Humility is honesty and depth of vision, a realistic assessment of ourselves and our part in the scheme of things. It places us in a true relationship with a Higher Power."

It seems to me by listening to the tapes and by appraisals of my sessions with K realistic and fearless assessments of self are almost impossible when shame is around. It is a hindrance to and entirely different from humility.

6.4.2 Shame – anxiety.

Wurmser (1981) talks of shame as a specific form of anxiety evoked by the imminent danger of unexpected exposure, humiliation and rejection. Anxiety he says is two fold.

"Either it is a response to the overwhelming trauma of helplessness already experienced,like the trauma of massive exposure and rejection in the Emily scene in David Copperfield…or the humiliation that led to Ajax's suicide in Sophocles' play. Or shame may function merely as a signal, triggered by a milder type of rejection and warning lest a more intense one reach traumatic proportions; the signal affect thus prevents regression to the traumatic state. The specific term used by Piers and Levin for this type of shame is shame anxiety"

(p50)

He then asks the question "Isn't there a contradiction between the definitions of anxiety as 'imminent danger' and as a 'response to trauma'?" My sense is it's both. My dissociation, which was a response to anxiety, came both at the anticipation of an

abuse event and as a result of it. Wurmser (1981) offers an answer to his question by referring to Rangell (1980) who stated that

> "The danger in trauma is in its continuing, or getting worse, or never stopping, and, in its worst form, of its eventually over-running the resources of the ego to the point of its extinction."
>
> (p24)

I have often wondered if in dissociating I was saving myself from annihilation, both physically and emotionally by my own hands as well as by the hands of my abusers. I feel certain that dissociating was an effect of anxiety; an anxiety brought on by a combination of stressors – fear of the trauma, the humiliation and shame of it and the sense of the 'rejection' of love associated with it, all of which Wurmser (1981) acknowledges. But also, I think for me the most important factor, because of the innate feeling of what was happening being 'wrong'. It was a violation of 'my' sense of moral rightness. The shame of going against an innate sense of what is right is highly anxiety provoking and thus shameful. (see table 4)

6.4.3 Shame – rage.

Anger is an acknowledged emotion in response to abuse. (Courtois 1996: Bass & Davis 1988: Sanderson 1995). Many survivors, it seems, are unable to express their anger overtly. It is certainly a major issue in therapy for me. I do not seem to be able to express the deep sense of rage and outrage that is inside me and I have often expressed to **K** my real fear at the consequences of the unleashing of this rage. He has also often said that he is not afraid of this anger while respecting that I am. **Leah** is undoubtedly 'my' voice of anger.

Whilst anger is closely related to the responsibility and guilt that survivors feel about their abuse (Sanderson, 1995), it is also closely related to how they feel about themselves and to the moral and religious teachings they may have had as children. Females in particular are socialised not to express anger. It is not a lady-like quality! If a woman cannot discharge her anger externally she may resort to internalising it. It manifests itself in destructive behaviours such as eating disorders, self harming and suicide attempts. This is reinforced when internal negative messages tell her that something bad has happened to her therefore she must be bad, so any anger must be directed at her. I am aware of the suicide attempts I made in times of utter desperation and frustration, seeing no other way out. Often survivors vent their anger against themselves through self-blame, self contempt and self defeating behaviour. (Courtois 1996) Even after years of therapy at worst I can still blame myself for it ever happening and at best I see myself as having colluded with my abusers. Beginning to shift this blame and responsibility brings with it the danger of increased anger and rage at the possible injustices that occurred should I not be to blame.

Religious attitudes play their part in anger. Being taught that we must "turn the other cheek" when 'abused' by another and that we must forgive "seventy times seven" does not offer a climate for the expression of anger, even justifiable anger, to a child in an adult world. If this becomes a part of a child's identity it will become a major obstacle in therapy for the adult.

If anger has been denied to the abused child then she may grow up believing she has no right to her anger. **Helen** often talks of her fear of getting angry.

H. I'm not allowed to get angry.
K. You're not allowed to get angry……Who said that?
H. If I get angry they'll get the belt out.

K. Uh huh. If you get angry who'll get the belt out?
H. S.
K. S'll get the belt out if you get angry.
H. If I get angry the Leah comes out and she gets us into trouble. (Tape 20)

I have an inordinate sense of fear about getting angry. I have often told **K** that I do not have the right to be angry but also that I am terrified that once I start to unleash the rage that is inside me, it will never stop and the destruction would be irreparable.

Having listened to the tapes over and over again one of the things that began to dawn on me was that 'my' resistance to expressing justifiable anger was due to the fact that shame remained a serious issue. It was a block to acknowledging anger as a right. Underland-Rosow (1996) acknowledges that unwanted shame is often hidden by distractions of which rage is a common diversion. Rage, she says, like shame is all consuming.

"People feeling rage may not be aware of their surroundings or of what they are saying or doing."
(p88)

In expressing rage shame is being hidden or denied. I can see this can happen. However my experience is that the opposite can also happen. If shame is embedded deep into the psyche because of a sense of guilt, blame or because of teachings then an expression of anger will only add to that sense of shame and is to be avoided at all costs. This is a block to therapy as new data cannot be taken in while either rage or shame is around. Both need to be addressed. In bypassing either, then it seems to me that we leave the tools for self destructive behaviour in place. (see table 4)

6.5 TRIANGULATION.

Once again I gave my findings on shame to **K** for his thoughts and this time felt even more vulnerable to his response. It seems the fear and the shame never seems to be too far away. I was aware that I still could not give him eye contact even more so during this session. His opinion of both me and this study is of great importance and he managed to put me at some ease right from the start

K. I think this is an excellent expose on shame…the way you tease out the various elements of it……..I like the way you kind of leave it hanging and don't necessarily come down on one side or the other. (tape 179 triangulation on shame)

Reading this chapter opened up a discussion between us. **K** felt he had always been aware of the level of shame that was around but seeing it written down brought home to him the enormity of it for me.

K. I've heard over the time we've worked how deep the shame is for you and how all pervading it was and still is but I think when I see it in writing it um….it just indicates how um….how powerful it was and how powerful it still is. (Triangulation tape. Tape 179)

Talking to **K** in this session made me aware of the cycle of abuse and dissociation keyed by the emotion of shame and how this prevented other emotions from being expressed..

A. It just seems to me to be a vicious circle…the whole thing is a circle….um….what happened….OK if I go back to then rather than speaking from now…but then it…what happened felt shameful so I was ashamed it was happening…..um….and because it wasn't happening to other people or I couldn't see it happening to other people….that fundamentally meant there was something wrong with me…there was something flawed in me which made me ashamed again…and because it was shameful it had to be hidden…so there was shame around the fact that there was a

secret….and then when I got older and realised that again it wasn't happening to anyone else and that it felt wrong and I knew it was wrong…it felt innately wrong…then there was shame around me not doing anything about it….and so it took on an identity…It was my identity and because of that nothing else could happen…I couldn't take anything else on board…nothing else could get through…just this shame …and dissociation was the answer. It was just a vicious circle
K. And it's had a profound ….an enormous effect on you. It just brings it home powerfully for me when I see it written down. And it feels that the liberation in breaking free of this shame can be enormous as well.
A. So for me shame …and fear were the two keys to that emotional prison
K. Yes absolutely.
A. There was the physical fear and then there was the emotional shame of it all. …hidden…and they were the keys…because of the shame it was almost that I didn't have the right to anything else
K. Yes.
A. I didn't have the right to be angry…I didn't have the right to feel happy.
K. No …nor did you have the right to feel…wronged…because you were being blamed.
A. It was almost that I didn't have the right to justice.
K. Well you had no rights at all had you?
(Triangulation tape.Tape 179)

Even this discussion in the session was triggering a sense of shame – that I should even be having this conversation at all. For a few moments I felt like a child in the confessional. This led me to talking about my religious influences and how I feel they played an important part in compounding how I felt as a child.

A. And I still say…I keep going back to it….I still say…if I hadn't belonged to a religious family…I don't think it would have been quite so…um….what's the word I want….I just felt that what I was being taught as fundamental ethics…at school, in church compounded everything I was feeling….
K. Oh yes!
A. ….because it hammered guilt into it.
K. And also the adults were the icons.
(Triangulation tape.Tape 179)

K was struck particularly by the section on shame and humility.

K. Um…the bit that most strikes me is…the part of …I forget the actual title of it…it's um positive shame?....Where you explore that?
A. Um….Oh yeh!.....

K. Healthy shame….Um and I think it's really good the way that you explore that….It seems to me um…that ..ambivalently…um in the context of humility (K is thumbing through the text here)…um and explore humility…You do that exceptionally well.

(Triangulation tape. Tape 179)

I think this exercise of triangulation in particular has made me very aware of the value of feeding back to the research participant what I have found. It has highlighted the importance of this finding and shame has been and still is to some extent a barrier to therapeutic movement. We also now are aware that we need to spend more time in therapy to explore this emotion and the damage it can cause. I was able to identify that shame has been a block on 'my' ability to be angry.

CHAPTER 7.

CONCLUSION.

7. CONTRIBUTION TO THE FIELD OF DISSOCIATION AND THE AIMS OF THE RESEARCH.

Even with information given in the very best of self-help books and academic literature there are sometimes, some things we cannot do alone. We need the help and support and the expertise of someone else. For me that someone else was **K.** But the "experts", the academics, the clinicians, the therapists, the **K**'s of this world also need to be informed and who else better to help inform than the client/patient. There is a need and a role for 'user led' approaches to research which are based on equipping and resourcing disabled people and other service users to initiate their own research, developing their own research focuses and questions. Beresford (2004) says

> "Service user researchers value their own experiential knowledge and that of other people. They question hierarchies of knowledge based on traditional assumptions of credibility and validity…..Both government and non-statutory research funders have responded to this emphasis on 'service user involvement' in research. Organisations as diverse as the Medical Research Council, Joseph Rowntree Foundation and ESRC are now requiring evidence of it from bidders. Senior academics now need and are developing new skills to make this possible. (p3)

In his essay Beresford started with his own personal experience as a mental health service user and highlighted what for him are the "close and important inter-relations" between who he is and what he seeks to do in his work as a professor. He expresses how his experience of the changing role of the professor also highlights the need to

address "the interconnections between the personal and the academic and the gains that are got from doing so" (p4).

When starting out on this research I became very aware there was a vast amount of research in a great many areas around the contentious subject of dissociation and Dissociative Identity Disorder. I became increasingly aware of the dearth of material around the area of DID clients' feelings and emotions and even less from the eye of the clients themselves. There were accounts of how living with DID can affect daily lives in cameos and vignettes in text books written by clinicians and in personal books written by those who experience DID. To my knowledge there has never been any research undertaken by a client with DID currently in therapy. I took heart in both McLeod (2002) and Beresford (2004) who advocate user led research and took the need to relate theories to personal experience. In doing so I have tried to replace the approach of selecting the 'correct' theoretical explanation from a series of choices and instead looked at 'organic' complexity. As therapists it is the personal complexities of the individual that we deal with.

This thesis is an original contribution to research in that, to my knowledge, it is the first research undertaken to specifically look at what emotions *may* be around for someone experiencing Dissociative Identity Disorder. It is also unique in that it is done by the client (who also happens to be a therapist) whilst still in therapy. This case study together with the overview of the literature available has implications for other people - therapists, clinicians, those who experience DID and for those who are just curious. The systematic collection and analysis of data sets it apart from the writing of a book based on pure autobiographical reflection. The main purpose of this

empirical research is not to 'prove' the existence of DID through personal testimony. This would not be possible as clearly the sceptic would remain unconvinced. The aim is to help others understand more about the phenomenon and its effects and to give an insight from the 'inside'. Hopefully it will be a bench mark for further research. I am making no claims that what has been found in this research will automatically apply to everyone with DID. However it gives an insight into what feelings *could* be around for someone with DID and perhaps will encourage others to acknowledge and respond to their own emotions with a greater belief in self. If this research encourages one other person living with DID and its effects to look closely at how they feel without guilt or fear and encourage therapists and clinicians to help their clients explore these emotions without backing away then this study will have been more than worthwhile. I sincerely hope that there are gains to be made from this research which will benefit both those who experience dissociation and for those who help and work alongside them. One of the most important gains for me as a therapist is that it has furthered my awareness of human reaction to trauma and it has also given me a greater understanding of and insight into the world that I inhabit. McLeod (2003) talked of how he sees research in relation to the reconstruction of practice and how it contributes to the creation of communities of practice. I hope this research enhances public understanding of DID and its effects.

The aim was not to produce dry theory or hypotheses but to offer further and perhaps deeper insights into some of the emotions that *may* be around for someone with DID and how this effects outlook and behaviour in the hope that it will contribute to the developing understanding of DID.

7.1 QUALITIES OF THIS RESEARCH.

7.1.1 Methodology

The quality of this research for me lies firstly in its qualitative nature. It is the in depth study of experience which as a therapist working with DID clients I find of more benefit than statistics. As a case study it provides a unique and holistic contribution to our knowledge of the phenomenon of DID and rose out of a desire to understand its complexity. Being a case study it has allowed the investigation to retain the holistic and meaningful characteristics of real-life events. Secondly, it is a study in the search for truth and not necessarily certainty.

The qualitative approaches of heurism and grounded theory gave rise to the opportunity of time spent in the immersion of the subject and the material gathered. It was the heuristic approach which seemed to sit better with me. For me it was a more appropriate approach to looking at emotions in that it felt a sensitive yet still rigorous approach. The grounded theory seemed less sensitive and more intrusive so I made the decision to use grounded theory for one tape and for heurism for the remaining nineteen tapes.

"The power of heuristics is in its recognition of the significance of self-searching and the value of personal knowledge as essential requirements for the understanding of common human experiences. There is no substitute for, direct, comprehensive, accurate first-person accounts of experience, for the importance of self-inquiry and self-dialogue in discovering the nature and meaning of one's own experience and that of others." (Moustakas 1990 p90)

This research is paradoxically a first person account in that the experience is mine but also that of 'my' alters.

"As the distinctiveness of experience is explicated into its unique qualities and themes and depicted through description, example, literary expression, narrative, and artwork, the researcher has gathered what is required to construct the universal portrayal of essence. The researcher intuitively and reflectively sees in all the depictions, the qualities or characteristic meanings that make the experience what it is and not something else – what enables one to know anger as anger, tranquillity as tranquillity, fear as fear and courage as courage." (Moustakas 1990 p90)

Having gathered together and closely analysed all the data a rich picture has emerged of how it can 'feel' to experience DID as a result of severe trauma, in this case sexual, physical and psychological abuse: a picture of how the experience is and what it means and its effects and not something else.

7.1.2. Use of Audio Tapes

The use of audio tapes was beneficial in several ways

a) It enabled me to revisit sessions time again and to transcribe the contents of each session. The sessions were lengthy and content can be forgotten particularly if they are emotionally charged. Recording sessions ensured little was lost.

b) Recording sessions also gave me access to unwritten emotions such as silences and nuances, voice tones and added displays of emotion such as tears.

c) Without recording the sessions I would not have had access to the alters as I do not have co-consciousness with them. Without their input this study would not have been so complete. They have brought richness and a viewpoint which 'I' alone could not have provided. They are after all an intricate part of DID.

7.1.3. Time span.

This research was conducted over a period of two-and-a-half years which gave an abundance of material to work with. It allowed for there to be movement in therapy showing that emotions are fluid and not static.

7.2. CRITICISMS OF THIS RESEARCH

This was addressed in the methodology chapter. However now that the research has been completed there are other criticisms I can note. All research has its limits and they need to be acknowledged.

7.2.1. Use of video

With hindsight video recording the sessions would have produced an added dimension and wealth of information to this research. **K** often commented that he wished at times a video recorder was available to capture the discrete changes in each of the personalities. Much could be learned from observing body language and facial expressions as well as the silences. However this would have produced practical and possibly ethical problems. 'I' was not prepared to 'use' the alters as visual curiosities.

7.2.2. Time Span.

The study was conducted during ongoing therapy and was limited to a time span of two-and-a-half years. Previous research earlier on in therapy uncovered different findings and similarly if done in a few months/years time I would expect the findings to be different again. It seems to me it could be beneficial to continue research covering the full length of therapy in order to give a more complete picture. However

I do not think that this necessarily in any way lessens the value of the findings but is perhaps indicative of part of a process that has had to be gone through.

7.2.3. Previous Research in this Field.

As far as I could deduct there is no research with which to compare and contrast this to. I have been able to feed it through traditional theory and literature but there is no benchmark for this research. However all research has to start somewhere.

7.2.4. Generalisability

One of my biggest fears in doing this research was around the credibility of researching myself and the fact that it was a single case study. I have been constantly aware of not allowing this project to become an exercise in wallowing in self pity or a therapeutic exercise although to some extent it has been that by the very nature of the heuristic approach to it. As Moustakas (1990) says

> "Heuristic inquiry is a process that begins with a question or problem which the researcher seeks to illuminate or answer. The question is one that has been a personal challenge and puzzlement in the search to understand one's self and the world in which one lives. The heuristic process is autobiographic, yet with virtually every question that matters personally there is also a social – and perhaps universal – significance" (p15)

I acknowledge that I have found therapeutic advantages in doing the research and at times wished I have never undertaken the project as it uncovered very painful discoveries.

One of the criticisms about qualitative research in general is its tendency to researcher bias and this can be extended here as I am both the researcher and the researchee. I

have tried to redress this balance by both feeding the findings through the traditional literature and by referring to my research participant all the way through as a point of triangulation for his perceptions of both the process and the findings. I am making no claims that what has been found in this research will automatically apply to everyone with DID. However it gives an insight into what feelings *could* be around for someone with DID and perhaps will encourage others to acknowledge and respond to their own emotions with a greater belief in self. If this research encourages one other person living with DID and its effects to look closely at how they feel without guilt or fear and encourage therapists and clinicians to help their clients explore these emotions without backing away then this study will have been more than worthwhile. I sincerely hope that there are gains to be made from this research which will benefit both those who experience dissociation and for those who help and work alongside them. I hope too that this will be a benchmark for further research.

7.2.5. Transferability.

Transferability refers to the degree to which the results of qualitative research can be transferred to other contexts or settings. In the naturalistic paradigm the transferability of a working hypothesis to other situations depends on the degree of similarity between the original situation and the situation to which it is transferred. As the researcher I cannot specify the transferability of findings. I can only provide sufficient information that can then be used by the reader to determine whether the findings are applicable to the new situation (Lincoln and Guba 1985). It seems to me anyone with DID who is interested in understanding their emotional state or needs and how these affect their daily functioning could take this research and apply the methodology to their own search with the support and cooperation of their therapist. This methodology could also be used by non-DID clients who are also seeking further

understanding of their psychological well being. As a therapist I have been able to look at the findings and how they were obtained and apply the process to some similar situations with clients I work with. Using audio tapes (for some clients) gives clients an opportunity to revisit sessions and reflect, bringing them to a deeper understanding of their situation and helps them to initiate change.

7.3 RECOMMENDATIONS.

Several things became clear to me from this project

1. The use of audio tapes in the counselling sessions reaped enormous benefits for me in this research. I was able to go back and revisit sessions and this gave me the opportunity to look at things I had missed or had misunderstood or indeed had forgotten.
2. In working with DID clients short term therapy is not ideal. Trust is an enormous issue with abused and dissociative clients and it can take months/years for these clients to build up a relationship with a therapist. Working with DID is complex and time consuming. Counsellors taking on these clients can realistically expect long term therapy.
3. The heuristic approach felt right for this research. As Sela-Smith (2002) concluded about the value of heuristic research

"I know that if I want what I experience in my outer world to change, I must search internally to discover what caused me to create the external experience." (p85-86)

I knew that if 'I' want to make sense of my internal world and thus afford changes in my external world I needed to search both internally and externally. As Sela-Smith (2002)continues

"By establishing the need to include …the *I-who-feels* in individual.

> professional and cultural quests for knowledge in research theory and in practice, perhaps there may be recognition that the world we have jointly created is a mirror of our collective internal tacit knowledge. As we become conscious of the last frontier, the interiority of the self as experienced by the self, we may learn how to consciously transform both the internal experience and the outside world. (p86)

7.4 RECOMMENDATIONS FOR FURTHER RESEARCH.

Inevitably the process of research throws up thoughts and possibilities for further investigation and this study was no different. Working my way through it posed several ideas.

Although I am aware of the enormous commitment that research of this nature takes both in time and personal involvement I would dearly like to see others with DID doing similar studies so that some generalisability could be posited.

I became very aware of the influence that religion and a religious (in this case a Catholic) upbringing played in the production of dissociation in my life. I would like to see research done to look further into both the incidence of and the effects of religious influence in DID.

My fantasy would be to see research done covering the full time spent in therapy and a follow up to therapy study undertaken.

There were also other emotional effects which this study could not realistically include, one of which is fear. Along with shame, fear for me, is also a key to the emotional imprisonment discovered. I would like to see an in depth study of the effects of *fear* in relation to dissociation as seen directly from the eye of the client.

My observation is that children can respond to stressful situations in two ways. They can become compliant children or they can become rebellious and disruptive. I was a compliant child. It would be interesting to compare the results of this research with someone in a similar situation who responded as a rebellious child.

7.5. WHAT I HAVE LEARNED.

Doing this research has given me the courage to stand up and be counted. For a long time whilst doing the study I questioned whether I would be able to publicly put my name to the work. I have often doubted my own sanity and have feared how others would not only view the research, but also how they would accept that I practice as a counsellor. One of the effects of abuse and DID is the inability to discern what are rights and 'I' can own in my own right. Whilst I still remain shy about my own DID years of ego based therapy have given me the chance to develop a strong sense of self and to be aware of my limits and abilities. I am slowly accepting that 'I' can be who I am. I am also highly aware of the need for all counsellors not just myself to take care of themselves. It is not a selfish act.

I have learned that in working in a highly client centred way my counsellor has met my needs as a client with great alacrity and this has encouraged me to approach therapy with my clients who have DID in the same way. It seems to me that in working with DID there is no one universal approach. Therapy for each client needs to be tailor made just as each client and their internal system is unique.

Using audio tapes in my sessions has led me to using them with some DID clients and have found it particularly beneficial when working with those who do not have co-consciousness with their personalities. It gives them an opportunity to meet them.

The research has given me a golden opportunity to learn, to seek out knowledge which has both informed me on the one hand and disenchanted me on the other. Therapy has given me the ability to balance this. Together with my own lived experiences this has in turn equipped me well to work with others who are walking a similar road as me. The continuing debate over the validity of DID has made me ever more determined to meet clients where they are and to try not to judge. I can see both sides of the debate but my own experience leaves me on the side of the post-traumatic model. The current research into the psychobiological field heralds a possible new era and a need to rethink the debate.

Most of all I have come to realise that if I put my mind to something, with help, I can make attempts to overcome and understand my DID and in doing so impart some knowledge that may help others.

7.6 CONCLUSION.

I have no doubt that Dissociative Identity Disorder and other dissociative disorders provoke both fascination and consternation and we have yet to resolve the debate about the authenticity of DID. DID cannot stand in isolation. It has to be seen in the light of its cause – in this case childhood abuse. Meanwhile those of us who live with DID on a daily basis continue to strive to live out our lives to the best of our ability. It is often a lonely and frightening existence. In seeking counselling I am aware that my

resolve was to move from what I now recognise as existence into what I dearly desire – living. I would challenge DID as being a "psychiatric disorder" in itself. I see it as a being a highly developed and sophisticated method of self defence and is a normal adaptive response to severe trauma and not a psychotic response. I would feel happier to see it described as Dissociative Identity Existence rather than Dissociative Identity Disorder. I am not sure that a technique designed to protect fits into the category of a disorder.

In response to Spanos' (1985, 1994) view that DID is a therapist/media suggested condition I need to ask again "Why does this just apply to DID and not to other 'disorders'" If I am so suggestible why did I not develop other disorders and why should suggestion affects apply only to DID? I do not think Spanos' view holds much credence. The media portrayal of mental illness in drama, soaps and the increasingly popular chat shows could provide me with information around a whole host of 'disorders' from obsessive compulsive disorder, phobias, bipolar disorder and sexual disfunctions to name but a few. To ask again Why therefore don't suggestible individuals identify with these and why don't sufferers of these conditions get accused of being influenced by the media?

The purpose of this study was to discover a client's perspective of some of the emotions experienced from living with DID currently in therapy and the possible effects on behaviour. There has been no systematic collection of data to be explored and analysed in this field of DID as far as I have been able to uncover and certainly not from the perspective of a client in therapy. I discovered that whilst DID can elicit

many feelings, at the stage in the counselling process used for this study there were two majorly dominant themes

1. A sense of emotional imprisonment.
2. Shame.

7.6.1 A sense of emotional imprisonment.

Denying someone the right to their emotions is like denying someone the right to their senses. Abuse is almost always done in secret. The victim is told s/he must keep what is happening from others for many reasons – "It is our little secret". "No-one will believe you", "You will go to prison or you will be taken away". There are also the overt threats of safety to themselves or to family or pets. Because this must be kept from the public arena there develops the need to keep emotions from the public arena for fear of betraying what is happening. Emotions need an outlet and it seems that dissociation can be a way of providing that outlet. It was my way. It became second nature to keep feelings under wraps and as an adult for me to believe that 'I' do not have the right to my emotions and certainly not the right to express them. It also had the effect of me not knowing what feelings are appropriate and to question this. This in turn had the effect of 'me' feeling isolated and somehow not being a 'real' and valid member of society. It appears that much of the expression of the internalised and hidden emotions was kept and experienced by 'my' alter personalities. Dissociation safeguarded 'my' sanity and allowed 'me' to function on a daily basis. I brought this learned behaviour into an adulthood existence. It is this that led to a sense of being in an emotional prison. The task of therapy is then is to penetrate the prison to bring a freedom – a freedom of emotional expression that is free of question and guilt and perhaps to an ultimate point where dissociation becomes irrelevant.

Gottman's (1999) theory that we wear masks to suit occasions resonates. He feels that wearing our masks has benefits and has researched over many years how married couples 'wear' their masks and the effects this has on their relationship. His results show that often keeping these masks in place keeps a marriage together quite successfully. However my sense is that living our process can be hard but living our masks can be costly. The mask of dissociation whilst preserving 'my' life and sanity has been costly in keeping me a prisoner of 'my' own emotions.

7.6.2. Shame.

I was surprised and disappointed to find little attention given to the emotion shame in the literature written about abuse and DID; although usually acknowledged, it was given little space for exploration. It seems to have been bypassed and I am left asking the question "Why?" Perhaps as therapists we sometimes want to make everything better for our clients and shame is difficult to 'cure'. Also when listening to the shame of our clients it can tap into our own and if we are uncomfortable with our own shame then we may avoid it in others. If we do not deal with shame as it arises we are in danger of becoming 'stymied' as therapists and of isolating and marginalizing our clients even further. Shame by its very nature involves disconnection, alienation and separation. I would also have to agree with Underwood-Rosow (1996) that people are unable to process new information while they are experiencing shame. It was a dawning realisation for me to discover that shame was inhibiting my expression of anger. I am left wondering what other emotions could be inhibited by shame.

I note too that disenchantment was contributory to my dissociation. The reality of life can be hard to bear and the future can look even bleaker. It is little wonder if then

disenchantment sets in. This disenchantment can develop into shame if there seems to be no-one to help or there is no way out. Shame then becomes internalised and becomes what Bradford (1988) describes as a "characterological style". It becomes an identity.

I found in this research that shame was playing an important part in therapy. I see dissociation as a denial of shame and that it is a way of hiding the truth. Dissociation is a way of dissipating emotion adding weight to my theory that dissociation is a coping and a defence mechanism.

Shame is a weapon used by perpetrators to control the victim. Tell a child often enough that what is happening to them is their own fault; that they have caused it and along with it happening in secrecy, behind closed doors, the child will take on board the sense and atmosphere of shame. Add this to external factors such as religious and social teachings and customs and the child will become further isolated and resort to defence mechanisms. Shame weighted with humiliation can produce the deep, entrenched feeling of being "enshamed" .

7.7 AND FINALLY.....

To go back to the question of the extent to which the findings of this research, as a single case study, can be generalised to other studies. Even though critics may argue that it is difficult to draw inferences that can logically be applied to other studies from one account of an experience or from one study, I do believe that a rich source of learning and understanding can be gained from this method which deserves a hearing.

I saw heuristic research as an invitation to self-dialogue which would give me the opportunity to be honest with both myself and my experience relevant to the question. Its power lies in its potential for truthful discovery and revelation and since heuristic research uses qualitative methodology to arrive at themes and essences of experiences, the question of validity is one of meaning. If the process is entered into honestly, thoroughly, with openness and without constriction then the ensuing findings will be invaluable in their field. This experience can then be drawn upon in the same way that others have been drawn upon in the process of this enquiry. Subjectivity is its strength.

I continue to have an ambition and that is to some day move the disbelief and suspicion of the sceptics to an awe and wonderment at the ingenious lengths that the human psyche can go to protect itself, giving me, and others like me, the freedom to work unfettered by fear of discredit.

Appendix A.

DISSOCIATIVE EXPERIENCE SCALE.

The Dissociative Experience Scale (DES) was developed by Frank Putnam and Eve Bernstein Carlson. The overall DES score is obtained by adding up the 28 item scores and dividing them by 28: this yields an over all score ranging from 0-100.
A typical question is, "Some people have the experience of finding new things among their belongings that they do not remember buying. Mark the line to show what percentage of the time this happens to you." The respondent then slashes the line, which is anchored a 0% on the left and 100% on the right showing how often s/he has this experience.

The following are items included in the DES
01 Able to ignore pain
02 Missing part of a conversation
03 Usually difficult things can be done with ease and spontaneity.
04 Not sure whether on has done something or just thought about it.
05 Absorption in television program or movie.
06 Remembering the past so vividly one seems to be reliving it.
07 Staring into space
08 Talking out loud to oneself when alone.
09 Finding evidence of having done things one can't remember doing.
10 Not sure if remembered event happened or was a dream.
11 Being approached by people one doesn't know who call one by a different name.
12 Feeling as though one were two different people.
13 So involved in fantasy that it seems real.
14 Driving the car and realising one doesn't remember the trip.
15 Not remembering important events in one's life.
16 Being in a familiar place and finding it unfamiliar
17 Being accused of lying when one is telling the truth.
18 Finding notes or drawings that one must have done but don't remember doing.
19 Seeing oneself as if looking at another person.
20 Hearing voices inside one's head.
21 Not recognising one's friends and family.
22 Other people and objects don't seem real.
23 Looking at the world through a fog.
24 Finding unfamiliar things amongst one's belongings.
25 Feeling as though one's body is not one's own.
26 Finding oneself in a place but unaware how one got there.
27 Finding oneself in clothes one doesn't remember putting on.
28 Not recognising one's reflection in the mirror.

[Taken from the internet 09/02/2000: The Ross Institute-Dissociative Experiences Scale; copyright 1996-99. from Ross, C. 1989 '*Multiple Personality Disorder; Diagnosis, Clinical Features and Treatment.* New York: Wiley.]

Appendix B.

LOOK FOR DID IF THERE IS A PATTERN OF....

01 History of depression or suicide
02 Childhood history of physical, sexual, emotional or psychological abuse...reports one parent was very cold and critical; reports of "wonderful" parents by a person who is clearly emotionally troubled.
03 Strong attacks of shame: sees self as bad or undeserving: Sacrifices self for others: feels does not deserve help; is a burden, reluctant to ask for help; is sure you do not want to be troubled with seeing him/her.
04 Reports being able to turn off pain or "put it out of my mind"
05 Self- mutilation or self-injuring behaviour.
06 Hearing voices.
07 Flashbacks (visual, auditory, somatic, affective or behavioural)
08 History of unsuccessful therapy.
09 Multiple past diagnoses (e.g. major depression, schizophrenia, bipolar disorder)
10 History of shifting symptom picture.
11 Reports of odd changes or variations of skills or interests.
12 Described by others as having 2 personalities or being a "Jekyll and Hyde"
13 Family history of dissociation
14 Phobia or panic attacks.
15 Substance abuse.
16 Daytime enuresis or encorpresis.
17 History of psycho-physiological symptoms.
18 Seizure like episodes
19 History of nightmares or sleep disorders
20 Reports psychic experiences
21 Anorexia or bulimia
22 Sexual difficulties.

(Part of a document issued by the 'Divided Hearts Reading Room' giving information on signs to look for in DID)

Appendix C.

INSTRUCTIONS TO RESEARCH PARTICIPANT.

Date _____

Dear_____,

Thank you for your interest in my dissertation research on the experience of **Dissociative Identity Disorder**. As my counsellor, you and I have worked together for almost 6 years now and you participated in my MA research, the findings of which I can safely say gave us both insights and teachings around the human psyche and human reaction to trauma. It was not easy research and the experience has taught us that the research and process for this PhD thesis is likely to be just as difficult.
We have been through traumatic and rewarding experiences connected with both my history and my dissociation and you are well aware of the emotional strains that exist for us both. It is because of the trust, confidence and respect that I have for you that I asked you to participate in my MA research, the subject of which as you know is a deep passion of mine. I could not have done it with anyone else. My trust in and respect for you is now even deeper and there is no doubt in my mind that you can facilitate work which, I hope will produce further valuable findings for us (personally/professionally) and for this PhD project. You have brought me this far. It is because of this experience that I have approached you again. I value very much, the unique contribution that you can make to my study. Still nervous, I am also excited at the prospect of your involvement again in this project. The purpose of this letter is to reiterate some of the things that we have already discussed and to secure your signature on the participation-release form which you will find attached.

The research model I am using is a qualitative one through which I am seeking comprehensive depictions and descriptions of my own experience of dissociation and its effects In this way I hope to illuminate or answer my questions, **"How does it *feel* to live with Dissociative Identity Disorder?/ What are *my* overriding *feelings* in living with Dissociative Identity Disorder? What are some of the long term effects of Dissociation?/What bearing does the therapeutic relationship have on an effective management of DID?/What will the therapeutic implications be as a result of this study?**

We already tape record my counselling sessions with you and through your participation as counsellor/co-researcher, I hope to understand the essence of the phenomenon as it reveals itself in my experience. You are asked to continue to facilitate these sessions just as you have done for the past six years. We have agreed

that I will take responsibility for the tapes and for deciding when to record. However should one of my alters present her/himself during one of these recorded sessions then you will tell her/him what is happening and obtain their permission to continue recording. Once this research has been completed it has been agreed that you will keep the tapes in a safe place until further required. Perhaps one day we can publish a joint paper on the subject and on our experiences of the therapeutic process.

I understand that I may use your observations and comments as they are made in the sessions and once I have gathered my findings I will present them to you for your comments and perceptions. This will either be achieved by an informal interview or by writing to be agreed at a later date.

As a counsellor you have your support strategies in place in the way of ongoing supervision etc. and you will be responsible for maintaining this. My support continues to come from within our counselling relationship.

I value enormously your participation and thank you for your dedication and commitment of time energy, and effort. If you have any further questions before signing the release form, I can be reached at Tel…….. or e-mail……

With heart felt thanks

Appendix D.

PARTICIPATION-RELEASE AGREEMENT.

I agree to participate in a research study of **Dissociative Identity Disorder** as described in the attached narrative. I understand the purpose and nature of this study and am participating voluntarily. I grant permission for the data to be used in the process of completing a dissertation for a PhD. degree including any other future publication. I understand that my name and other demographic information which might identify me will not be used.

I agree to meet at the following location,_____at a mutually agreed time for the counselling sessions of 11/2-hour each. I also grant permission for the tape recording of the sessions.

I am aware that I may opt out of the research project at any time.

_____
Research Participant

_____
Primary Researcher

_____
Date

_____
Date

Appendix E

COPYRIGHT PERMISSION E-MAIL FROM PATRICIA KARG

From: Univ.-Prof. Dr. Anton H. Schwabegger
[anton.schwabegger@uibk.ac.at]
Sent: 11 January 2002 07:41
To: anne@thebreakthroughcentre.co.uk
Subject: Job and Karg

Dear Ms Burdess

thank you for your interest in my illustrations.

I am very pleased if you can use my illustrations for your thesis, but I would be very pleased also, if you can send me an exemplary of your thesis after completion for my convenience and documentation.

Good luck for your elaboration efforts and for your work
to help children.

yours sincerely

Karg Patricia

(translated and sent by her partner Dr. Anton Schwabegger, Plastic Surgeon)

Please also see

www.karg-patricia.com

Appendix F

GLOSSARY OF TERMS.

Alternate Personality (Alter): A distinct identity or personality state, also called an identity or dissociated part. A distinct identity or personality state, with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self. Modified from *DSM-1V.* p770 "Alters are dissociated parts of the mind that the patient experiences as separate from each other". *ISSD Practice Guidelines Glossary,* 1994.

Co-consciousness. For a person with DID (MPD), this is the awareness of the thoughts, feelings, beliefs, needs etc of other personality states.

Co-existing disorders. Refers to cases in which an individual has more than one mental disorder as described in the *DSM-1V.* Also known as co-morbidity.

Dissociation. The separation of ideas, feelings, information, identity or memories that would normally go together. Dissociation exists on a continuum. At one end are mild dissociative experiences common to most people (i.e. daydreaming or highway hypnosis) and at the other extreme is severe chronic dissociation such as DID 9MPD) and other dissociative disorders. Dissociation appears to be a normal process used to handle trauma that over time becomes reinforced and develops into maladaptive coping.

Dissociative Identity Disorder or Multiple Personality Disorder. One of the dissociative disorders in *DSM-1V.*There are four diagnostic criteria.

- The presence of two or more distinct identities or personality states.
- At least two of these identities or personality states recurrently take control of the person's behaviour.
- Inability to recall important personal information that is too extensive to be explained by forgetfulness
- The disturbance is not due to the direct physiological effects of a substance or a general medical condition.

DID is the current name for Multiple Personality Disorder (MPD), first used in *DSM-1V.* In addition to the name change, the criteria was increased by two items, items C and D. The term DID is felt to reflect more accurately the condition of an individual with two or more personality states. This change recognises that MPD represents the failure to form one core personality rather than simply create many personalities. Adapted from*DSM-1V.*

DSM-1V. Diagnostic and Statistical Manual of Mental Disorders. The fourth edition of *the Diagnostic and Statistical Manual of Mental Disorders (DSM-1V)* was published in 1994 by the American Psychiatric Association. It contains standard definitions of psychological disorders. *DSM-111-R* refers to the third edition, revised, of the same manual, published in 1987. The diagnostic categories referred to in the trauma literature published in the late 1980s and early 1990s are those from the *DSM-111-R.*

False Memory Syndrome. Deemed to be false memories of abuse implanted into a client/patient by the therapist either by using suggestion or pressure or by the use in therapy of the 'truth' drug, Sodium Amytal. A society called the False Memory Society has been set up for the victims of false memory syndrome.

Fusion. "...the moment in time at which the alters can be considered to have ceded of their separateness..." (Kluft, 1993. p109)

Guilt. A feeling that is evoked by a specific behaviour that is seen as wrong or unacceptable. Guilt is felt for making a mistake.

Integration. "[An}...ongoing process of undoing all aspects of dissociative dividedness that begins long before there is any reduction in the number or distinctness of the personalities, persists through their fusion and continues at a deeper level even after the personalities have blended into one. It denotes an ongoing process in the tradition of psychoanalytic perspectives on structural change." (Kluft, 1993. p109)

Host. In DID the personality state that most frequently has control of the body and its behaviour. The host is often initially unaware of the other identities and typically loses time when they appear. The host is the identity that most often initiates treatment, usually after developing symptoms, the most common symptom being depression.

Post Traumatic Stress Disorder. (PTSD). An anxiety disorder based on how an individual responds to a traumatic event. According to *DSM-1V.* the following criteria must be met.

- The person has experienced a traumatic event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and the person's response involved intense fear, helplessness or horror.
- The traumatic event is re-experienced in the specific ways such as recurrent and intrusive distressing recollections or dreams of the events.
- Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness.
- Persistent symptoms of increased arousal, such as hypervigilance or irritability
- Duration of the disturbance (symptoms B, C and D) is more than one month
- The disturbance causes clinically significant distress or impairment in functioning.

PTSD may be acute, chronic or with delayed onset. Many individuals with DID also have PTSD. The literature sometimes describes DID as complex and /or chronic PTSD. Adapted from *DSM-1V,* p427-429.

Shame. A feeling of inadequacy at the core of self. Shame is felt for being a mistake.

Splitting. In DID "splitting" is considered an outdated term, although it is often still used. Historically the formation of an alter personality state was conceptualized as a split from the original personality or birth personality suggesting there is a finite number of personalities that can occur during the splitting process Current thinking by the leaders in the field (Putnam, Kluft and others) indicates that pretending to be other people, or trying out different roles is a normal dissociative phenomenon in young children, which is intensified when trauma occurs, resulting in the creation of alter personality states. Thus the term "splitting" and "split personality" are no longer relevant when referring to the formation of personality states.

Switching. The process of changing from one already existing personality state or fragment to another personality state or fragment. Switching may be set off by outside stimuli such as an environmental trigger or by internal stimuli such as feelings or memories. Switching may be observable, such as changes in posture or facial expressions as well as changes in voice tone or speech patterns. Switching may also be observed by changes in mood, regressed behaviour and variable cognitive functioning.

Trauma. A medical term for any sudden injury or damage to an organism. Psychological trauma is an event that is outside the range of usual human experience and which is so seriously distressing as to overwhelm the mind's defences and cause lasting emotional harm. Psychological traumata include natural disasters, accidents or human actions, such as child abuse, rape, torture, kidnap etc which cause the victim to be terrified, helpless and under extreme physical stress. Most individuals with DID have been the victims of repeated trauma and generally also exhibit symptoms of post traumatic stress disorder.

Type 1 and Type 11 Trauma are terms developed by Lenore Terr to describe different types of trauma. A single traumatic event such as a fire or single rape episode is considered to be Type 1 Trauma. Repeated, prolonged trauma, such as extensive child abuse, is considered to be Type 11 Trauma. According to Terr's formulation of this concept, these two types of trauma result in different coping styles. Individuals with Type 1 Trauma receive support from family and friends and usually remember the trauma event. Individuals with Type 11 Trauma are more likely to have severe PTSD symptoms, such as psychic numbing and dissociation. Type 11 Trauma is often kept a secret and support from family and friends may be absent. Terr, *Unchained Memories,* p11, 30.

Trigger. An event, object or person etc that sets a series of thoughts in motion or reminds a person of some aspect of his/her traumatic past. The person may be unaware of what is "triggering" the memory (i.e. loud noises, colour, smell music etc). Learning not to overreact to triggers is a therapeutic task in the treatment of dissociative disorders.

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